ROCKY MOUNTAIN MEDICAL JOURNAL

Title Registered U. S. Patent Office

JULY 1961

Volume 58, Number 7

Publication Office
835 Republic Building
1612 Tremont Place
Denver 2, Colorado
Telephone AComa 2-0547

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Articles

Organization

Features

Meetings—Programs

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How to help your patient stick to a diabetic diet

The secret ingredient in a successful diet is acceptance. A diabetic diet that contains measured amounts of popular foods is sure to win the cooperation of the patient. All the more so if the variety of dishes is great. Bouillon or soup might start the meal. Chops, chowder, stews, broiled tomatoes, even spaghetti and meat balls can be adapted as tempting main dishes in a diabetic diet. Sugar-free preserves, water-packed fruits and sorbitol ice cream make delicious stand-ins for sweets. For parties, low-calorie wafers and raw vegetables make good nibbling.

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A medical potpourri

Compiled by Andrew M. Babey, M.D., Las Cruces, New Mexico

1. "It would seem therefore that children with acute nephritis can safely be allowed to get up much earlier than has been the practice in the past. One might arbitrarily say that they can get up and about as soon as hematuria visible to the naked eye has disappeared." Leading Articles: Bed Rest in Acute Nephritis, Brit. M.J. 2:939 (Nov. 7) 1959.

2. "Vasodilator drugs are not likely to increase bloodflow in the ischaemic foot, and fall in bloodflow which often follows their administration could prove disastrous to the critically nourished foot after an acute occlusion. Whether given by mouth or intravenously, they have no place in the treatment of acute arterial occlusion, or of the chronically ischaemic foot." Gillespie, J. A.: The Case Against Vasodilator Drugs in Occlusive Vascular Disease of the Legs, Lancet 2:995 (Dec. 5) 1959.

3. "As vasodilators do not increase calf-muscle blood-flow, and often decrease it, prescribing them for intermittent claudication is useless." Ibid.

4. "Professor J. McMichael concluded by suggesting that long-term anticoagulant therapy for coronary artery disease should be abandoned." General Articles and News: Occlusive Arterial Disease, Conference at Royal College of Physicians, Brit. M.J. 2:1091 (Nov. 21) 1959.

5. "Under the heading of food allergy as much harm as good has been done to mankind by the medical profession. In the absence of demonstration of blood reagins, scientific criteria for the diagnosis of food allergy remain sketchy and difficult to apply. Strongly positive intradermal responses to injection of foods must represent an abnormal state, since they do not occur in the majority of people. But to conclude on this evidence alone either that the patient has a food allergy or that his symptoms are due to food allergy is naive." Brock, J. F.: Nutrition and the Clinician, Lancet 2:923 (Nov. 28) 1959.

6. "This is an important point which has received insufficient emphasis, for it suggests that potassium restoration is all that is required to overcome an acute obstructive episode in Crohn's disease—and this is so. It is now a long time since I have had to operate as an emergency on account of obstruction in this disease; the acute attack can always be overcome by electrolyte restoration . . . not so with ulcerative colitis; obstruction is an urgent indication for emergency surgery of the most arduous nature (primary colectomy, in fact)." Brooke, Bryan N.: Granulomatous Diseases of the Intestine, Lancet 2:745 (Nov. 7) 1959.

7. ". . . failure to receive an optimal amount of culture is a personal misfortune, comparable to deafness or blindness." Dock, William: Curiosity, Culture, and Curricula, J.A.M.A. 172:643 (Feb. 13) 1960.

8. "In any attempt to raise the cultural level of physicians in the United States, one must contend with the lack of respect, if not contempt, with which the great literary and artistic traditions of humanity are treated in North America. In New York City, musical comedies of little merit draw crowds for years, while a moving production of Tolstoi's 'Power of Darkness' will draw an audience of about 200 on good nights for a few weeks." Ibid.

9. "In plans for a more intense cultural education for physicians this opinion must be taken into account, for many fledgling physicians share the national attitude and are repelled rather than attracted by obligatory courses in humanities or social sciences." Ibid.

10. "Gibbon, ruminating on the folly and lack of cultural interests of so many well-educated Roman emperors, concluded that "the power of education seldom has any efficacy save in those happy dispositions where it is almost unnecessary." Ibid.

11. "The current system of selecting students for medical school rarely places much value on the curiosity and zeal for self-education which, along with having cultured parents and spending one's childhood and adolescence in a cultured neighborhood, form the real basis for an interest in the great traditions, and in the cultural growth of the race." Ibid.

12. "*We, as a profession, must do something to interrupt this search for 'genius in bassinets.'* The

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RADIOLOGIC REFLECTIONS

Shadow or substance

Marcus J. Smith, M.D., Santa Fe, New Mexico

Apothegm

"How often have I said to you that when you have eliminated the impossible, whatever remains, however improbable, must be the truth?" (Sherlock Holmes.)

Clinical data

A 66-year-old lady responded well to treatment following the onset of symptoms of congestive heart failure. Three months later, fever and dysuria developed, and a chest film was obtained. Thirteen years before, a cyst had been removed from the "back of her brain." Seven years earlier, a right nephrectomy had disclosed a hypernephroma'. The patient had also received gold for rheumatoid arthritis.

The chest film (Fig. 1) showed multiple, small, round densities scattered through both lungs, characteristic of metastases. A calcium plaque was noted in the aortic knob.

Clinical course

The patient was seen periodically for control of her cardiac disability and renal symptoms. Ten months later, another chest film (Fig. 2) showed

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Fig. 1

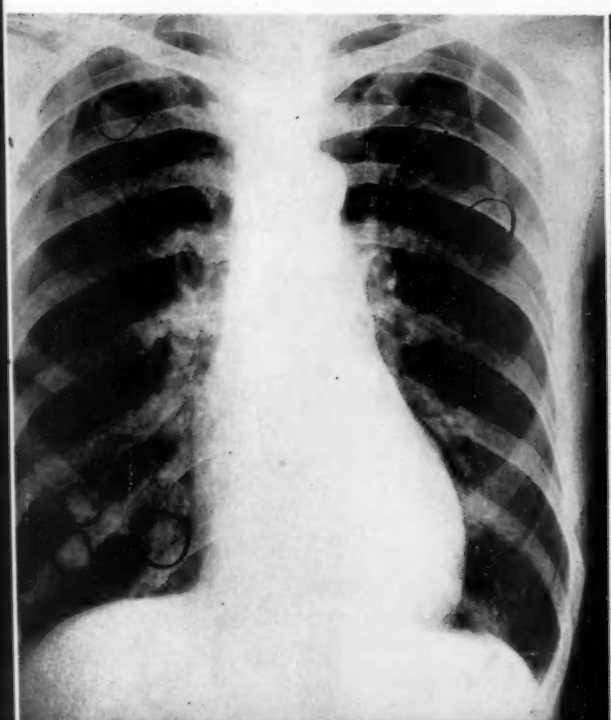
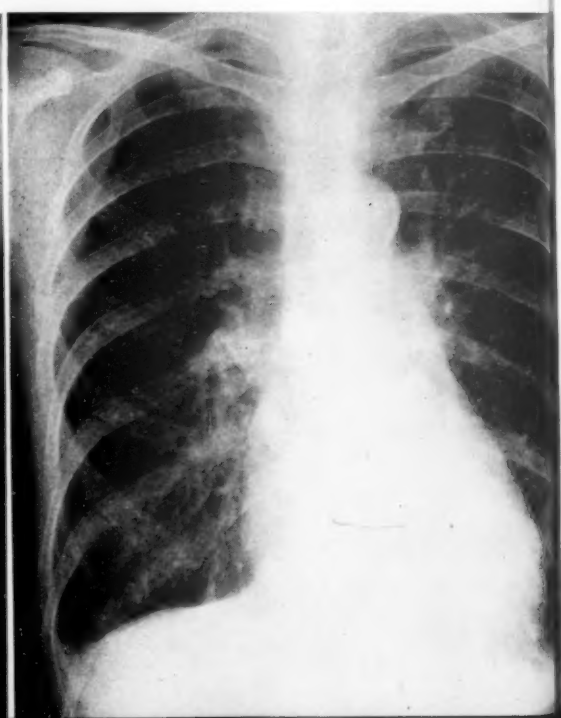


Fig. 2



*More "Din Of Inequity"**

THE FOLLOWING is copy of a letter sent by a Utah colleague to the legislators in Washington from his state:

What a shabby, half-hearted program we have outlined for our venerable senior citizens of America: half-priced medical care. Why do we falter and stop here? Not only do these citizens deserve good medical care, but they also have to have the other necessities of modern life—food, clothes, housing, transportation, television, vacations and many other services and commodities. Just because they achieve the respectable age of 65 does not mean that their needs and desires disappear. In addition to medical care they need legal advice, dental care, groceries, hair-cuts, suits and dresses, cars, gasoline, utilities, repair services, housing, and many other things—the same as before retirement. If we really revere these older people we should go all the way and see that they get all of the above-mentioned things. The President maintains that they cannot afford good medical care on lowered retirement income; neither can they afford the other things. Not only doctors should lower their fees to these people, but all the others (lawyers, dentists, grocers, barbers, tailors, car dealers, realtors, plumbers, etc.) should do the same. Doctors do not wish to monopolize this privilege of rendering service at reduced cost to the senior citizens, but heartily invite everyone else to participate in this great humanitarian effort.

In truth these older people are human beings with feelings and a sense of honor and obligation to pay their way. If our Social Security benefits are so skimpy as not to provide these individuals with the goods and services to which they are entitled, then it would seem simpler and better to elevate the benefits to a level adequate to take care of these needs. Besides, many senior citizens are discriminated against by not having Social Security. Are they to be left out? It is high time that our legislators gave this problem some sane consideration—or does this seem too motivated by a sense of fair play for all concerned?

L. O. Learned, M.D.

This points up how ridiculous it is to go all out for *one* facet of human requirements for a single segment of the population—or, should we say, block of votes! Wonder if anyone ever considered distributing the costs of medical care as a cash payment to the senior citizens and leaving it to them to buy their own services? Or, as Dr. Learned implies, it could be more fair and less expensive simply to raise pensions to cover all reasonable basic requirements.

On further thought, maybe the American people are softening themselves so that the lowest social stratum is composed of one carno boat families. Only the sky limits the rest —and they'll go along with any Great White Father or rich Uncle who'll promise them *the works* with maximum pay, minimum work, all health and other fringe benefits, and comfort during the sunset years.

*Be sure to read the special contribution by Mr. Ray M. Peterson of New York City to the April 8, 1961, J.A.M.A., using a portion of this title.

Quick, Watson, The Needle!

NEWSPAPER COLUMNISTS, like all human beings, vary in stature and ability. Many of them do splendid jobs of informing the public, criticizing, analyzing and interpreting the news. Others become slapstick exhibitionists, little men trying to act like big men —sounding off in areas where a little, if any, knowledge is a dangerous thing. We cannot forget Ruark's recent ridiculous diatribe against physicians and the A.M.A. We are reminded in passing of a remark by "Peanuts," the naive little character in the comic strip. He decided to become a doctor, not an ordinary one; he must aspire to reach the loftiest heights, becoming the greatest doctor of them all—the writer of a syndicated health column!

One of the good writers recently struck a nail squarely on the head: He said that the multi-billion dollar aid to education program is like giving a blood transfusion to an ailing man. The only trouble is—when the government does it—it's like taking the patient's own blood from the right arm and injecting it in his left, and spilling 90 per cent of it on the way!

This simile goes also for government control of medicine, medical practice, and hospitals. If you don't believe it, ask Great Britain. Helping the weak at the expense of the strong has gone too far when the weak become weaker without the necessity to help themselves. When the strong give up after being bled white, politics takes over and the welfare state creeps in. Human selfishness grows and masses of people put out hands to claim their share of the great give-away. Strikes and more strikes; more political appointments, but greater unemployment; feather-bedding; nepotism (defined by Webster as "favoritism shown to nephews and other relatives; bestowal of patronage by reason of relationship rather than merit")! It appears to be more than a coincidence that waning of traditional American guts has been coincidental with the expanding market for tranquilizer drugs.

The end result is devaluation of the dollar. Heaven forbid a war to boost our economy temporarily. There is legitimate doubt that America is in position to afford another F.D.R.-type administration. When 60 instead of 40 per cent of our populace is riding on the backs of others, and we are trying to get along on a 25-cent instead of a 50-cent dollar —then we'll have the answer!

Creeping Bureaucracy

In a recent issue of the A.M.A. News we learn that dues are to be raised. This announcement in itself is scarcely news. Dues usually stay put for a limited time, only, and inevitably the change is upward. Never in the history of man have dues been lowered. Be that as it may, when one reads further in the announcement, one's nose inevitably detects the unpleasant smell of budding bureaucracy.

For years the American Medical Association has strongly opposed governmental control of this and that. "This," metaphorically, means the growing of corn, the extermination of cockroaches, education of the next generation, and human endeavor in general. "That" means the Practice of Medicine in particular. Doctors as a class have always abhorred petty dictation and doubtless always will. An M.D. is a man who has labored through years and years of expensive education because he is the sort of creature who doesn't care to be bossed. He doesn't like to have his life regulated by a manager, a bureau, or a successful politician—especially when the managing body or person has no real knowledge of the doctor's job in life, which is usually the case. As anyone may observe, the course of bureaucracy is malignant and as the years pass, more petty bosses, more petty clerks, more directives and more money are needed.

So we—at least within the locker room—resent this trend in the A.M.A. The oldsters who worked their way through college aren't sure about subsidization of the medical student. They are suspicious of such generalities as advice, public education, communication expansion and the rather euphonious phrase, "Faithfully portraying the image of the A.M.A." Of course, dues will be raised but in the meantime, while posing for years as an antibureaucratic body, let's not set up a bureaucracy right in our own back yard.

Q. B. Coray, M.D.

*April 22, 1905— An Editorial**

Every man in every town during the course of a lifetime has to ask a favor of an editor —not an exception to this rule. A man may escape a doctor, keep clear of the courts, but once in a lifetime, at least, every man has to go to the newspaper to have a certain piece put in a death notice, a marriage notice, etc., to have a certain piece kept out or to have his name printed in, or omitted from, some item. It is, therefore, to your interest to treat the editor fairly. He desires to be fair; he would rather do the right than wrong thing but, if you give him a kick, the dent of it may be found in the top of your own hat someday and you will never know how it got there. Don't think that you are immune; don't think that providence has especially favored you. Your time will come, and when it does come, it will be a fine investment if you have a friend in the editor's office.

*By W. H. Hildreth, Editor and Publisher, in Basalt Journal (weekly).

Shoe on the Other Foot?

AMONG OTHER RESOLUTIONS introduced before the House of Delegates at the Midwinter Clinical Session of the Colorado State Medical Society was one concerning an inaccurate Scripps-Howard release by one of its science writers. An anonymous physician had asked the Question and Answer Section of the J.A.M.A. about Salk antipolio vaccine. The consultant had answered the question with unfavorable criticism of the vaccine, and it appeared that his answer had been misinterpreted by the columnist as the official opinion of the A.M.A. —which it was not. The resolution concluded as follows:

"BE IT RESOLVED, That the Colorado State Medical Society recommends to the officers of the A.M.A. that the Scripps-Howard Syndicate be advised of the above facts, and recommend that they should demand of the Scripps-Howard Syndicate public retraction of the misrepresentations of this release; that a copy of this resolution be submitted to the local news agencies for publication, so that the people of this state may be assured that the Salk vaccine has been proved to be effective as officially reported by the A.M.A. House of Delegates; that the opinion of the efficacy of this vaccine by the medical profession has not been altered by this newspaper article, and that this Society continues to advocate and urge immunization for poliomyelitis with this vaccine, on the widest possible scale."

Science writer John Troan took exception in a letter to the editor as follows:

Dear Sir:

In the May, 1961, issue of the Rocky Mountain Medical Journal there appears, on page 58, a reference to a story I wrote for the Scripps-Howard Newspapers, including the Rocky Mountain News, last March 1.

This story was based on statements berating the Salk polio vaccine which were published in the Feb. 25 issue of the Journal of the American Medical Association. These statements, appearing in the "Questions and Answers" section of the Journal to which physicians look for professional guidance, were invited by the editors of the JAMA and then endorsed by them in telephone conversations with me.

My story specifically pointed out that this advice which the JAMA was transmitting to the medical profession "conflicts with the A.M.A.'s own endorsement of the Salk vaccine." It noted that the A.M.A. House of Delegates, at its clinical meeting last fall in Washington, had "proclaimed this vaccine 'has proved to be effective' and urged its 'widest possible use' pending availability of a new, live-virus preparation that can be swallowed."

The wording of the resolution passed by the Colorado State Medical Society, demanding an apology from me (or, rather, a "public retraction"), is based on a misconception for the paragraph which precedes it states that my story indicated the statements in the JAMA constituted "the official opinion of the A.M.A." My story said no such thing.

I do not believe any conscientious physician can condone the action of the JAMA in inviting a known foe of the Salk vaccine to deliberately express derogatory opinions about this product contrary to the weight of scientific evidence and to pass these on to its readers as the views of a competent authority. This is irresponsible medical journalism which I felt obligated to expose.

I would appreciate your publishing this letter in the Rocky Mountain Medical Journal so that members of the Colorado State Medical Society may be aware of the true facts.

Sincerely,

John Troan,
Science Writer.

This small controversy is singularly unimportant compared with any incidental or residual loss of public confidence in the Salk vaccine caused by the Troan column. If we misinterpreted Mr. Troan, this editorial may be dubbed a hasty apology. However, it is amusing to note another writer crying when the shoes get on the wrong feet. He has now had just a small taste of what our profession suffers at the hands of the press daily, both in articles and editorials, "Public health education" in the public press often fails, or doesn't even attempt, to tell medicine's true story. When protested by our members and officers, we are accused of being oversensitive.

Thank you for your letter, Mr. Troan. No hard feelings on our part! Medical journalism isn't exactly irresponsible, as you state, but, for the most part, we limit our narrations to subjects within our own profession and which we do know something about. If we should insert a section with some such title as, "Newspaper Writing and You," or "Immunization Against Science Writers," our slips, too, would probably show frequently.

Who Is Abusing Whom?

A DENVER PHYSICIAN recently sent a timely letter to a regional newspaper regarding criticism of the Old Age Pension Medical Care Plan applicable in Colorado. Mr. Fred Pieper, regional director of the AFL-CIO, had in a previous newspaper article tried to "lay the blame" for admitted financial problems of the Colorado "medicare plan" on the doctors. Said our colleague:

Mr. Pieper of the AFL-CIO had many things to say regarding abuse of the plan, specifically with regard to medical and surgical fees, etc.

He was not satisfied with the fact that doctors were rendering their services for a fee well below their average fee. He wants it reduced still further.

It may interest Mr. Pieper to know that statistics recently released by the U. S. Labor Department Bureau of Statistics show that surgeons' fees in 1959 were 49 per cent of what they were in 1939, considering the real value of the dollar. I should like to have this compared to the increased cost of labor in the same period.

Furthermore, doctors are asked to, and are happy to, offer their services to the pensioner at

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Mass media and the physician . . . or how sick is our image?

Clyde E. Stanfield, M.D., Denver*

"In matters of private practice, the wishes of the attending physician or surgeon shall be respected as to use of his name or direct quotation, but he shall give information to the press, radio and television where it does not jeopardize the doctor-patient relationship or violate the confidence, privacy or legal rights of either the public or private patient . . ."†

VAST CHANGES HAVE EVOLVED in the physician's relationship with his public since the era of the frock-coated family doctor whose austere silence and authoritative mien contributed awesomely (and sometimes mainly) to his therapeutic armamentarium. Technologic advances, including those of communication, have combined with lay medical knowledge and interest to revolutionize the popular "image" of the competent (and other) physician. But alarming distortion of that image has accompanied its exploitation by hucksters and social pressure groups as a pawn for their own purposes. Even before Madison Avenue's "Four New York 'Doctors'" broke the laxative habit, the physician and his organized profession had lagged behind in the mounting contest for public recognition as a valued facet of society serving the public weal both as citizens as well as scientists.

Fig. 1

It is self-evident that medicine's truest image and best public-relations *modus* is the patient - doctor relationship, constructively maintained to fruition in a climate of voluntary and mutually responsible obligation. The physician's duty to his patient tests both his healing art and his scientific competency. But that responsibility cannot long be discharged if the physician's service is steadily undermined by attacks upon the integrity of his profession (individual or collective), by third-party restriction or manipulation of free-choice between patients *and* doctors. Thence arises a dilemma: should the private physician aggressively defend himself against regimentation; *i.e.*, against assault by pressure-group opinion-formers? Or should he archly confine himself to his eminent (?) domain: "Medicine, the jealous mistress"? In tragic irony medicine has achieved its fantastic technical advances of the last two decades while the private physician has lost public stature and understanding as he has shunned involvement in sociologic and political struggle in favor of the cloistered practice of his science.

*3705 E. Colfax Ave. The author is Chairman, Publicity Committee, Colorado State Medical Society, and Vice Chairman for Radio-TV, Publicity Committee, Denver Medical Society.

†Colorado's Code of Cooperation (between physicians, hospitals, press, radio, and television), April 18, 1948, amended to September 8, 1955.

Fig. 2

Aside from the physician's traditional noncombatant role in sociologic warfare, cultural changes also have threatened the patient-doctor relationship; *e.g.*, maldistribution of the profession amid population shifts, urban specialization within the profession, and third-party intermediaries (industrial, federal, or union group practices; governmental welfare programs; health insurance plans).

Competent surveys of public attitudes toward physicians reflect some revealing, often surprising inconsistencies—appropriate to the nature of human attitudes, stemming as they do from multiple unconscious and irrational feelings. Most patients, for example, trust and appreciate their own family or personal physicians—indeed, even feel he should be promptly paid (at least by the insurance company). But about the same majority distrusts "other doctors" and especially collectively (*viz.*, "The A.M.A.," the "Medical Society"). "Specialists" (other than "selfless researchers") come in for a share of suspicion, connoting social aloofness and superiority, higher fees, and alleged (usually falsely) economic advantage. "G.P.'s," on the other hand, have had to become "generalists" or "general specialists," because a "general practitioner" became typed not as one's family doctor but rather a doctor who'd had less training or hadn't been able to "make" a specialty.

Fig. 3

As one studies such surveys and listens to patients, the current fashion in idealized doctor-image appears to fantasize a warm and personable "family doctor" who is a bit of a specialist but can (and will) treat any illness; he is even more available by telephone or casual social (gratis) contact than by appointment, is clearly successful and in demand but charges minimal fees, is always punctual but accords generous time for discussion with patient and family, drives a late model car (less than Imperial, Continental or Cadillac); he is an active and altruistic participant in his community (other than in society columns) but always available for emergency call. Lest our perspective get too defensive, however—isn't this image close to the one we, as physicians, yearn for in a lawyer, President, or plumber? And are we free of irrational feelings about the National Association of Manufacturers or Colorado Bar Association? Is our concept of the individualistic farmer changed when we think of him as an affiliate of the Farmers Union? Clearly everyone's concepts are vulnerable to distortion by symbols, labels, and association.

Socrates, I believe, observed that a stick must have two ends. Idealism is but one end of the stick—the other is cynicism. As the physician-in-fact falls short of the physician-ideal (and the customer really didn't welcome needing his services anyway!), disillusionment compounds a "sick image" of medicine. One does not under-rate the importance of each physician's service to his patients, however, when it is recognized that the malady of our image may require more encompassing corrective efforts. It is doubtful that scientific achievement has rescued our image, and even more doubtful that we can surpass the perfected *art* of medicine practiced by our predecessors ahead of our vaunted science.

Medical technology has brought us problems, but perhaps nonmedical technology

can provide a key. If the physician's relationship and service to his patients can be multiplied by the thousand-fold *via* effectively utilized mass-media, he has the means to revalidate medicine's constructive image. The image-concept becomes factualized to the broader segment of the lay-public, as the physician takes tangible form as both human and helpful, both informed and informing.

To their credit, both the A.M.A. and many pioneering state (and a few county) medical societies have fostered public relations efforts over more than a decade—from the top. For example, the Colorado State Medical Society contracted in 1947 for a public relations survey, out of which arose its 1948 "Code of Cooperation" under the aegis of Dr. John Bouslog, then President of the Society. But the weakness of organized medicine's topside efforts so far lies mainly in its failure to induce dynamic and informed participation by the rank and file membership. Confusion and misconception about medical ethics—as well as outright fearfulness—are nowhere more evident than when the lone physician is approached by representatives of the mass media for quotation or appearance.

Fig. 4

A majority of physicians understandably shrink from individual publicity, from "taking a stand" in public controversy; reactively then, they suspect colleagues who too often appear in the public press. Such attitudes stem variably from honest humility to gross misinterpretation of the ethical tenets against professional "advertising" and solicitation of patients. But these tenets, while proper and meaningful, should be understood in context: it is concurrently also urged that physicians participate in "activities which have the purpose of improving both the health and well-being of the individual and the community."* Further, the Judicial Council (A.M.A.) has held that it is entirely ethical for a physician to respond to requests of his society to speak, write, or act for general

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*Sec. 10, Principles of Medical Ethics, A.M.A.

County medical society sponsors new home nursing service in Nevada

Dorothy C. Sutherland*, Reno, Nevada

PRIVATE PHYSICIANS in Washoe County, Nevada, are now able to obtain professional nursing service for their patients in their homes as a result of a program launched in January (1961) by the Washoe County Medical Society in cooperation with the City and County Health Department. In the three months the program has been operating, the five staff nurses of the Health Department have made 439 home visits to 32 different patients referred for home nursing care by their private doctors. It is the only visiting nurses service in the United States which is being provided by means of a contract between a county health department and a county medical society.

The need for home nursing was brought out in discussions before the County Medical Society as far back as November, 1959. By March, 1960, a plan had been worked out

*Miss Sutherland is the Chief of the Nursing Information Service, Division of Nursing, Public Health Service, Washington 25, D. C.

between the medical society and City and County Health Department and approved by the County Medical Society Board of Directors. It showed how home nursing care of patients could extend the physician's services, enabling effective treatment outside of hospitals for ambulatory patients, postoperative and accident cases, and chronic debilitated patients at home. The plan was approved for the City and County Health Department by the office of the Washoe County District Attorney and by the State Health Department. It was then formalized in a Statement of Agreement between the two sponsoring groups and a fee schedule was devised by the Health Department and approved by the Special Services Committee of the Washoe County Medical Society. The plan provides that the county medical society will be responsible for obtaining the funds by means of which the program will operate, and the Health Department is responsible for administration of the program and for expenditure of funds provided.

Dr. Earl N. Hillstrom, a member of the County Medical Society, was appointed special liaison for the visiting nurses service with the Health Department and was also given authority for fund raising. For the first six months of operation some $10,000 was contributed by citizens of the community together with donations from the Nevada Tuberculosis and Health Association, the Reno Cancer Center, and the National Foundation. Dr. John E. Palmer, President of the County Medical Society when the service was launched, and Dr. Richard C. Sheretz, currently President, are both giving it their personal support. The home nursing services are under the direction of Dr. William E. Winikow, City-County District Health Officer, and Mrs. Dorothy Minnis, Supervisor of Nurses of the Health Department.

Families of all income levels are eligible for home nursing, provided the private physician requests it. The maximum fee per visit is $5.00, regardless of the services rendered; no charge is made if the family is unable to pay. The State Welfare Department has also contracted with the Medical Society for visiting nurses service to Old Age Assistance cases in the amount of $2,400 per year.

TABLE 1

City and County Health Department and Washoe County Medical Society Visiting Nursing Service

January through March, 1961

Types of cases	No. of cases	No. of visits
Heart	9	145
Cancer	6	58
Tuberculosis	3	67
Accident	2	8
Arthritis	2	32
Diabetes	2	80
Infection	1	4
Senility	1	6
Disease of Digestive System	1	15
Anemia	1	5
Postsurgery Care	1	9
Hepatic Cirrhosis	1	5
Cerebral-vascular accident	1	4
Disease of Musculoskeletal System	1	1
	32	439

When the program was launched in January, only 18 local physicians were participating. However, the sponsors are striving for use by all 155 members of the County Medical Society currently resident in Washoe County. In the event this occurs, the goal is to raise additional money to enable the Health Department to employ one additional full-time nurse.

At present, the county is divided into five areas. Each of the five staff nurses of the Health Department is assigned to a single area and provides visiting nurse service to patients there, in addition to carrying out her traditional health department duties of helping to detect or prevent disease and to promote and teach good health. The visiting nurses service in the home might include irrigating or changing a catheter, giving an enema, giving insulin or other hypodermic injections, changing a surgical dressing, guarding against or treating pressure sores, giving medications, or any other specific nursing procedure ordered by the family doctor. Every physician who uses the service receives a written report from the nurse to

whom his patient has been assigned and detailed "nurses' notes" are kept in the files of the Health Department nursing office.

So far, doctors and patients alike are delighted with the program. The nurses giving the care say they, too, enjoy this extension of their own skills, and find home nursing one of the most satisfying aspects of their public health nursing experience. The service is available seven days a week and the time for home visits is usually scheduled to suit the patient's convenience whenever that is not in conflict with the medical care plan. •

Nodular tertiary syphiloderm resembling light sensitivity dermatosis

Robert G. Thompson, M.D.*, Salt Lake City, Utah

THE CLINICAL PICTURE of late syphilis of the skin is seen infrequently today. The recent literature contains warnings of dangers inherent in the prevalent belief that the problem of syphilis has already been solved[1,2,3]. These authorities point out, especially in view of the passing of diagnosis and management of syphilis from the hands of specialists to physicians in general, that there is need for constant awareness of the disease. Even in large clinics, tertiary cutaneous syphilis is now a relative rarity. Wise and Wolf[4] emphasize that correct diagnosis of tertiary syphilis is of importance, not only because of cutaneous manifestations, per se, and their progressive character, but because these cutaneous manifestations may be only a cloak for underlying organic involvement or implication of the cerebrospinal axis or cardiovascular system. Since statistical data show the serologic test for syphilis to be negative in a fairly large percentage of cases, some reports as high as 25 per cent of late cutaneous manifestations, this fact serves to indicate the importance of acquaintance with the varied clinical manifestations of syphilis in the skin. Recently we observed a case of nodular late syphiloderm occurring on the left forearm of a patient who had been diagnosed and treated for some time for light sensitivity dermatosis.

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CASE REPORT

A 71-year-old white retired Army Officer was first seen at Fitzsimons General Hospital in April, 1956, complaining of symptoms attributable to diverticulosis. His serologic test for syphilis was positive; cardiolipin microflocculation titer, 1:32; cardiolipin complement fixation, positive. Repeat examination revealed the titer to be constant.

In 1918, while serving in France, he contracted a "chancre" on the glans penis. This was treated in an infirmary with injections twice a week for two and one-half months, the exact nature of the treatment being unknown to the patient. From that time to the present, he had noted no signs or symptoms that he attributed to infection with syphilis. He had numerous physical and serologic examinations throughout his Army career, during most of which he was a food handler. Records received from the Surgeon General's Office, Department of the Army, revealed that in January, 1936, a cerebrospinal fluid examination showed a positive Kahn reaction of 4-plus. The patient does not know whether any treatment was administered and his medical records do not indicate that he was treated.

When his serologic tests were confirmed by repeat testing, a cerebrospinal fluid examination was done on 23 April 1956 which showed a cell count of 0; total protein, 47; colloidal gold, 0 0 0 0 0 0 0 0 0 0; cardiolipin microflocculation, negative 0.1 cc. and 0.25 cc., positive 0.5 cc. and 1.0 cc.

Physical examination was negative except for benign prostastic hypertrophy and skin lesions on dorsal aspect of left arm. These lesions consisted of two circinate eruptions, one forming almost a complete circle, 6.5 cm. in diameter, and another closely situated half-moon type lesion which, if

complete, would have been about the same diameter. These lesions were made up of a clearing center and a border of reddish nodules which appeared to be progressing peripherally. The center was covered with a thin, fine, white scale (Fig. 1). The patient attributed the eruption on the forearm to sun exposure which occurred while driving his car, since he was in the habit of leaving his left arm in the window. In fact, physicians had advised him that this was a sun-sensitivity dermatosis.

Complete neurologic examination, negative.

Laboratory data: Biopsy of the reddish nodule making up the periphery of one lesion was reported as "the corium has a relatively heavy infiltrate of chronic inflammatory cells, composed predominantly of histiocytes, lymphocytes, and plasma cells. In upper corium, this infiltrate is diffuse, but in deeper corium localization has occurred around blood vessels. These appear mildly to moderately thickened in some areas. Plasma cells are scattered infrequently throughout the infiltrate." The biopsy material was examined by The Armed Forces Institute of Pathology who concurred in the diagnosis of nodular tertiary cutaneous syphilid (Figs. 2, 3, and 4).

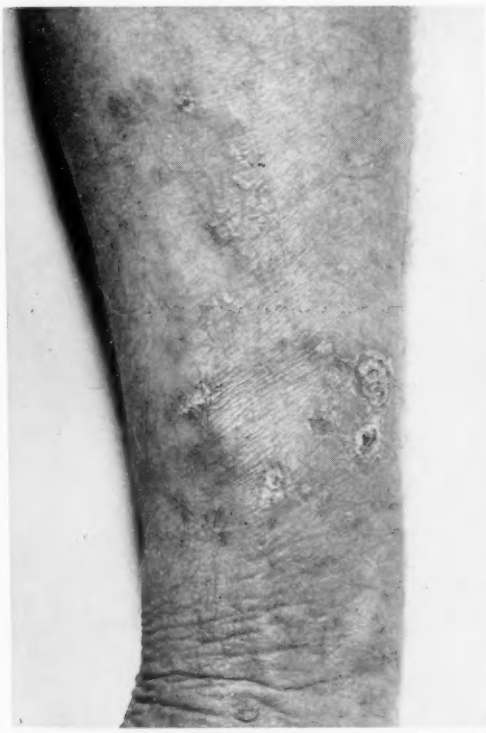

Fig. 1. Dorsal aspect of left forearm showing annular, arciform lesions of nodular tertiary syphiloderm with ulcerative phase just beginning. Pretreatment photograph.

On 4 June 1956, the patient was hospitalized and treated with 900,000 units of procaine penicillin G in oil, with 2 per cent aluminum monostearate intramuscularly, every day for a total of

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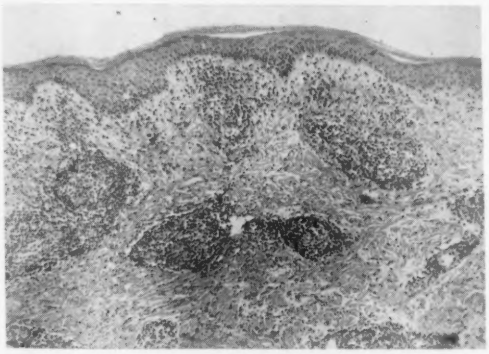

Fig. 2. Photomicrograph of corium showing focal accumulation of lymphocytes, histiocytes, and plasma cells primarily about blood vessels, X 95.

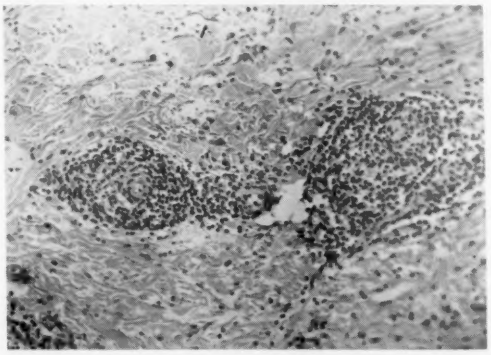

Fig. 3. Photomicrograph showing normal collagen bundles and focal chronic inflammatory infiltrate predominantly perivascular, X 350.

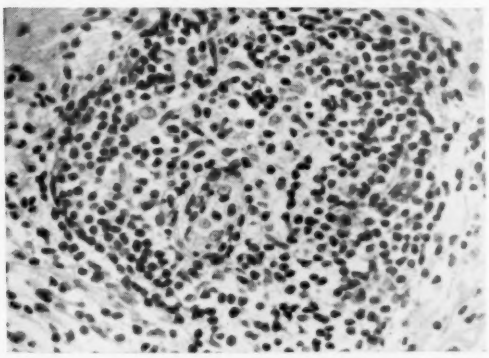

Fig. 4. High power (X 880) photomicrograph showing complete obliteration of blood vessel of skin. Many lymphocytes, frequent histiocytes, and occasional plasma cells are noted.

Aralen® and Plaquenil® in treatment of the common wart*

John C. Murphy, M.D., and Sadie Petty, R.N., Albuquerque, New Mexico

Encouragement in treatment of a common and frustrating nuisance—warts.

OF THE MANY KNOWN VIRUS DISEASES, probably the most common is the wart, more accurately termed the cutaneous virus papilloma. This essentially benign but frequently annoying skin tumor continues to present a frustrating therapeutic challenge. Warts are notoriously unpredictable in their response to any one of a great many treatment modalities. The fact that there are literally dozens of proposed plans for treating warts is evidence that no one method is satisfactory. The success of any means of treating warts must depend in the final analysis on complete destruction of the causative living virus particle. At present the most popular procedures—because they are most often successful—rely on some form of physical destruction. Such destructive measures include electrosurgery, curettage, application of various acids, x-ray, freezing agents, blister-forming chemicals, and even surgical excision. In many situations, however, the accompanying fright and pain as well as the ensuing disability and scar formation make destructive removal of warts undesirable or unacceptable. A safe, comfortable, and reasonably reliable systemic method of destroying warts would be most welcome in these problems.

During the past 15 years the quinacrine drugs have proved effective in the treatment of an increasing number of skin conditions. Following the suggestion of Ayres and Ayres[1], as well as several unpublished reports at the Academy of Dermatology meetings, a clinical study was started to evaluate the effect of the antimalarial drugs in treating virus warts. Treatment of warts with these drugs has also been recommended by Haynes[4] and Prazak[5].

Materials and methods

The drugs used in this study were oral tablets of Aralen† (chloroquine) phosphate 125 mg and 250 mg, and Plaquenil† (hydroxychloroquine) sulfate 200 mg. Dosage was based roughly on body weight. Patients under 40 pounds received 125 mg of Aralen daily; from 40 to 70 pounds, 250 mg of Aralen, or 200 mg of Plaquenil; over 70 pounds, 500 mg of Aralen, or 400 mg of Plaquenil. The medication was taken in divided doses twice a day, after meals. Each patient was examined at approximately three-week intervals until all warts were gone, until the trial was considered a failure, or until the patient failed to continue therapy. Patients were selected for this study because of:

1. Multiplicity of warts.
2. Difficulty of locations (peri- or subungual, facial, plantar).
3. Age (to avoid frightening experiences for young children).
4. Recurrence following previous treatment by other methods.
5. Desire to avoid painful disability from conventional destructive therapies.
6. Wish to prevent undesirable scar formation.

*From the Section of Dermatology, Lovelace Clinic, and the Lovelace Foundation for Medical Education and Research, Albuquerque, New Mexico. This study was in part supported through the Lovelace Foundation by Winthrop Laboratories, New York, New York.

†Aralen®, brand of chloroquine, and Plaquenil®, brand of hydroxychloroquine, Winthrop Laboratories, New York, New York.

A total of 281 patients was started on Aralen or Plaquenil treatment for warts.

Results

Of the 281 patients included in this study, 258 were followed to a known conclusion. Those who did not report for final examination were contacted personally by telephone or letter to obtain a reliable final analysis. There were 16 patients lost to follow-up, and seven who arbitrarily failed to follow instructions (Table 1). Results were classified as either "cured" (all warts entirely gone) or "failed" (any or all warts remained). Although a number of cases showed partial resolution with disappearance of a portion of multiple warts or partial regression of a single wart, these were all included in the "failed" group. Of the patients with known results, 166 (64 per cent) were cured and 92 (36 per cent) failed (Table 2).

Analysis of the results with different types of warts shows that 60 per cent of patients with multiple common warts (many in problem locations), 71 per cent of those with plantar warts (many also multiple), and 80 per cent of those with plane warts (verrucae plana juveniles) were cured (Table 3). The higher incidence of cure in plane warts corroborates the findings of Hall[2] and Bennett and Rees[3]. Of the 180 children (including adolescents) treated, 125 (69 per cent) were cured as compared with 52.5 per cent of the adults (Table 4). The finding of better results in children confirms the report of Berghorn[6].

The time of treatment for all cases followed was from three weeks to six months. Patients who discontinued therapy short of three weeks were considered to have failed to follow instructions. Several patients took the medication continuously and some intermittently for prolonged periods up to six months. The average time of treatment for the patients cured was seven weeks, with a slightly shorter average time for those taking Plaquenil (Table 5).

Several features were noted clinically which do not show in the tables. More recent warts responded more often and rapidly than did older lesions. Warts which had been previously treated responded less often and more slowly than did those with no previous therapy. In a number of cases, the warts finally disappeared several weeks or even a few months after Aralen or Plaquenil therapy was discontinued. In most of the successful cases the warts showed visible clinical changes — darkening (to almost black in

TABLE 1

Patients treated with quinacrines

	Total	Followed	Cured	Failed	Unknown	Discontinued
Aralen	165	153	102	51	10	2
Plaquenil	116	105	64	41	6	5
Total	281	258	166	92	16	7

TABLE 2

Patients followed to known conclusion

	Followed	Cured	Per cent	Failed	Per cent
Aralen	153	102	66.6	51	33.3
Plaquenil	105	64	61	41	42
Total	258	166	64	92	36

TABLE 3

Cure rate for different types of warts

	Total	Cured	Per cent
Multiple	168	100	60
Plane (verrucae plana juveniles)	20	16	80
Plantar	70	50	71

TABLE 4

Comparison of cures between children and adults

	Total	Cured	Per cent
Children	180	125	69
Adults	78	41	52.5

TABLE 5

Time of treatment, patients cured

	Aralen	Plaquenil	Total
Patients	102	64	166
Average time (weeks)	7.2	6.5	7.0

many cases), softening, crumbling, and flattening — before final slow disappearance. There were no residual scars of any kind, although many patients showed a temporary hypopigmentation or depression at the site of the former wart.

Side effects

Among the 258 patients followed in this series there were 37 (14 per cent) with reactions or side effects to the drug (Table 6). Most of the reactions were minor or mild and disappeared on stopping the medication. Nineteen patients reported gastro-intestinal symptoms including nausea, cramps, diarrhea, and excessive abdominal gas. Seven patients complained of anorexia or weight loss. There were six cases of skin rashes: two macular eruptions, two urticarias, one lichen planus-like eruption, and one moderately severe generalized exfoliative erythroderma in a patient who had psoriasis. Three patients described transitory visual disturbances. After three and nine weeks, respectively, of treatment the hair (including brows and lashes) in two children turned from brown to platinum blond.

TABLE 6

Side effects, all patients followed

	Aralen	Plaquenil	Total
Patients followed	153	105	258
Gastrointestinal	11	8	19
Anorexia and weight loss	7	0	7
Skin rash	4	2	6
Visual disturbances	3	0	3
White hair	2	0	2
Total	27	10	37
Per cent	17	9.5	14

There was a much greater incidence of side effects with Aralen (17 per cent) than with Plaquenil (9.5 per cent), and most of the more marked or startling reactions were in the former group (Table 6). Of the patients having reactions to the medication, 21 were able to continue or resume treatment and were cured of their warts, including the two with white hair. The 16 patients who discontinued treatment because of side effects failed to lose their warts. The only reaction which required anything more than stopping the drug was the exfoliative erythroderma in the patient with preceding psoriasis. In that case systemic and topical steroids controlled the reaction rapidly. This patient also lost a painful recurrent plantar wart.

Comment

Systemic chemotherapy of a common and therapeutically unrewarding virus disease—the wart—has been followed in 258 patients with a cure rate of 64 per cent. These results are not presented as evidence of a new "cure-all." It is well known that suggestion alone often cures warts, especially in children. The findings in this series need much further investigation and study. A double-blind clinical series with placebos is indicated. Serial biopsies, virus cultures, and electron microscopy might further clarify the mechanism of action of the quinacrines in the treatment of warts. It is stimulating to think that these drugs may have some virucidal or virustatic effect *in vivo*. Further evaluation of their effect on the virus papilloma might lead to a breakthrough in the field of specific antivirus drug therapy.

Summary

Of 258 patients with virus warts treated with oral administration of Aralen or Plaquenil, 166 (64 per cent) were cured. Plane warts responded best. Children were cured more often than adults. The average length of treatment was seven weeks. There were 37 (14 per cent) reactions to the medication, most of which were minor and transient. Further studies—both clinical and laboratory—seem indicated to evaluate the possible antivirus chemotherapeutic possibilities of these and allied drugs. •

REFERENCES

[1]Ayres, Samuel, III, and Ayres, Samuel, Jr.: Chloroquine in Treatment of Lichen Planus and Other Dermatoses. J.A.M.A. 157:136-138, January 8, 1955.
[2]Hall, William K., Editor: Warts. Bull. Assoc. Mil. Derm. 7:17, July, 1958.
[3]Bennett, James H., and Rees, Rees B.: Triquin (Triple Synthetic Antimalarial) in Dermatology. A.M.A. Arch. Dermat. 80:339-343, September, 1959.
[4]Haynes, Harley A., Jr.: Warts and Their Treatment. Ohio State Med. J. 56:1106-1109, August, 1960.
[5]Prazak, George: Warts (Verrucae). In Current Therapy—1960. Philadelphia, Saunders, 1960, p. 503.
[6]Berghorn, Bronson M.: Chloroquine Phosphate in the Treatment of Multiple Verrucae Vulgares. Bull. Assoc. Mil. Derm. 9:15-17, November, 1960.

Closed-chest cardiac massage*

Followed by use of external defibrillation

Prem Lakra, M.B.B.S., and K. H. Shipman, M.D., Denver

Unusual experiences in management of cardiac arrest are of general and timely interest.

KOUVENHOVEN RECENTLY DESCRIBED the technic of closed-chest cardiac massage for cardiac standstill and demonstrated its remarkable effectiveness. This method has been successfully employed in the treatment of several critical situations at The Presbyterian Hospital. The present report is being presented with the purpose of emphasizing the importance and great simplicity of this technic.

Case 1: A 66-year-old white female was admitted with an ovarian tumor which was removed surgically. The postoperative course was uneventful up to noon of the sixth day. At this time, the patient complained of "indigestion" to the nurse. About two hours later, the nurse was summoned to the patient who was found to have no pulse and only occasionally weak respiratory movements. Immediately, the nurse instituted closed-chest cardiac massage and then called for medical help. The house staff, on arriving, found that the closed-chest cardiac massage was producing good femoral pulsations. Positive pressure respiration was begun. An electrocardiogram revealed ventricular fibrillation. By this time, the external defibrillator and pace-maker were both available. One 250-volt shock by the defribillator was sufficient to convert the ventricular fibrillation to atrial flutter which spontaneously converted to sinus rhythm, about 15 minutes later (Fig. 1). At this stage the blood pressure was 120 over 80. For several hours thereafter, the patient exhibited signs of cerebral anoxia. She was unconscious and thrashed wildly in her bed. Her pupils were dilated and reacted poorly to light. Deep tendon reflexes were moderately active and bilaterally equal. Plantar reflexes were normal and there were no special signs localizing the central nervous system lesion.

The patient became lucid about eight hours later. Subsequently, serial electrocardiograms revealed a recent anteroseptal myocardial infarction. Over the next 24 hours, the urine volume fell. The period of hypotension during the phase of cardiac standstill with subsequent oliguria made one consider the possibility of renal damage. Careful control on fluids was instituted, and gradually the urine volume increased. The patient made good progress for the next eight days, but eventually lapsed into a phase of progressive refactory left heart failure. She expired on the tenth day following the episode of ventricular fibrillation.

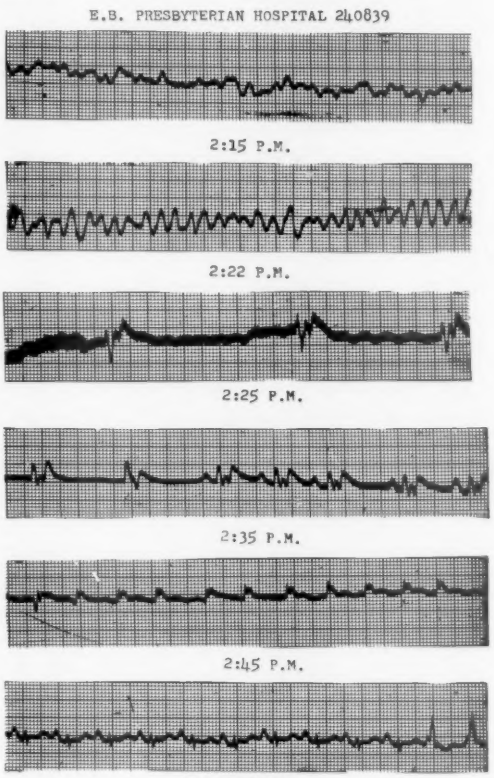

Fig. 1.

*From the Medical Service, Presbyterian Hospital, Denver. Acknowledgment: We wish to thank Dr. H. A. Bradford, Chief of Medical Service, Presbyterian Hospital, for his assistance and advice. Kouvenhoven, W. B. (and others): Closed-Chest Cardiac Massage. J.A.M.A. 173:1064-1067 (July 9) 1960.

Case 2: Mr. W. B., a 59-year-old white male, was admitted to the Medical Service on January 20, 1961, with a two-week history of progressive dyspnea, orthopnea and ankle edema. Two years prior to admission, the patient sustained a myocardial infarction and subsequently had been maintained on anticoagulation and vasodilators. The patient's congestive failure was treated with digitalis and diuretics. He was making satisfactory progress when, suddenly on the morning of February 2, he became unresponsive, pulseless, and without respirations. External cardiac massage was immediately instituted by the house staff and positive pressure respiration applied. It was interesting to note that, with cardiac massage, consciousness would return and the patient would become responsive. When massage was momentarily interrupted, the patient again lost consciousness. Upon restoration of external massage, consciousness would return.

An electrocardiogram at this time revealed a rapid ventricular fibrillation. External defibrillation was performed using a countershock dose of 350 volts. After a short run of ventricular tachycardia, the rhythm reverted to a normal sinus mechanism (Fig. 2). At this point blood pressure was obtained at 110/80, and the patient began complaining of anterior chest pain. Subsequently, he was placed on parenteral quinidine gluconate, 160 mgm. every three hours. The cardiac rhythm continued to remain stable.

The patient made adequate progress over the next 48 hours until he again, following a meal, became unresponsive, apneic, without blood pressure or pulse. External cardiac massage was promptly initiated by a practical nurse, until a member of the house staff arrived. Good femoral pulsations were maintained. An electrocardiogram at this time again showed ventricular fibrillation. External defibrillation was performed using a countershock dose of 350 volts. The rhythm converted to a sinus mechanism (Fig. 3) with restoration of blood pressure, respirations and consciousness. Vasopressors and oxygen therapy were continued until the next morning, at which time the confusion cleared and the vital signs remained stable. Subsequent electrocardiograms revealed a recent anteroseptal myocardial infarction and a lactic dehydrogenase on February 7 was 260 units (normal, 25-100).

The remainder of this patient's hospital course was marked by steady improvement. He became ambulant three weeks after his second lapse into ventricular fibrillation. Convalescence was afterward uneventful and he was discharged home.

Discussion

When the paper by Kouvenhoven was published last year it aroused great interest and discussion among the hospital staff. Over the next four or five months, the method of closed-chest cardiac massage was instituted on a number of patients with various types of grave illnesses at the time of cessation of cardiac activity. Satisfactory circulatory impulses were demonstrated but the underlying pathology in these patients rendered the efforts futile.

The great value of this method lies in its simplicity, and enables one who is familiar with it to start this technic immediately without risking delay in obtaining medical help.

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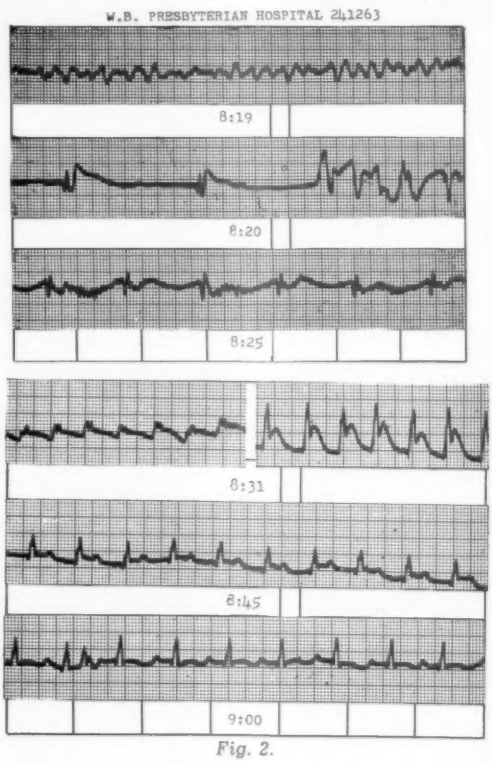


Fig. 2.

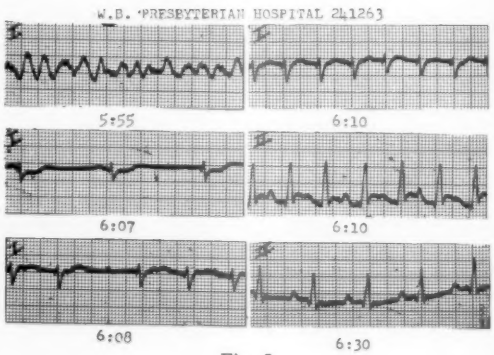


Fig. 3.

Maternal mortality in Montana

Robert J. Casey, M.D., Great Falls, and David Findley, M.D., Helena*

Montana's record is better than the national average but breakdown of the statistics shows there is still room for improvement.

THIS IS A LIMITED STUDY of maternal mortality in Montana for a five-year period. It is an attempt to elucidate some of Montana's problems with the hope that by so doing we may be able to further reduce the toll of mothers lost in the process of child bearing. The period covered is from 1954 to 1958, inclusive, during which time there were 23 maternal deaths—six in 1954, five in 1955, two in 1956, six in 1957, and four in 1958.

Throughout the past 20 years, with the exception of one year, 1950, the maternal death rate in Montana has been consistently lower than the maternal death rate for the United States as a whole. Of this the state can be proud, but unquestionably, there is room for improvement. National statistics[1] for the country show the percentage of maternal deaths from the leading causes as follows: Hemorrhage, 27.1 per cent; infection, 19.0 per cent; toxemia, 27.8 per cent, and other causes, 26.1 per cent. The national figures of maternal deaths resulting from heart disease are not available. In this relatively small series of cases that we have under consideration for the State of Montana we find the following: Hemorrhage, 52.1 per cent; infection, 21.7 per cent; toxemia, 8.7 per cent; heart disease, 4.3 per cent, and miscellaneous conditions, 13 per cent[2].

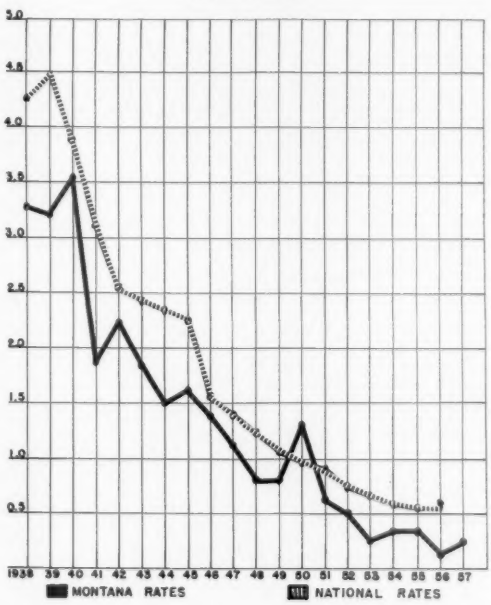
Hemorrhage

It is easy to see that hemorrhage has accounted for significantly more than one-half of the maternal deaths over this period of time. Of the mothers dying from hemorrhage, almost half of them succumbed because of a ruptured uterus which was post-traumatic, mainly following version and extraction. It was felt that injudicious use of intramuscular pitocin for induction of labor could have been a contributing factor in one of the cases of ruptured uterus. A third of them succumbed because of uterine atony. One died because of abruptio placenta, and only two succumbed because of hemorrhage from placenta praevia.

The basic treatment of hemorrhage, regardless of cause, is the administration of blood. There is certainly no question that in some of these maternal deaths from hemorrhage it was a question of "too little too late."

GRAPH 1

Maternal death rates, 1938-1957, per 1,000 live births



*Montana State Board of Health. Information for this study has been made available by the Montana State Board of Health, and through the analysis of maternal deaths by the Montana Medical Association, Maternal and Child Welfare Committee, and State Board of Health.

Undoubtedly, the geography of our state and the lack of dense areas of population contribute to the inadequacy of blood replacement facilities. However, it should be a community responsibility to see that adequate amounts of blood are available for immediate administration.

Traumatic rupture of the uterus frequently follows the use of high forceps or an attempt at version and extraction. The fact that almost half of these women who died of hemorrhage died as a result of trauma to the uterus with a subsequent rupture is an indication that close attention must be paid to this factor. We can only hope to achieve reduction in the number of deaths from this cause by a realization that these two procedures are not without danger and are procedures that are almost completely outmoded. Cesarean section can be wisely chosen in place of these two operations in almost every instance.

Atony of the uterus has always been a common cause of maternal death. It certainly calls for early recognition, adequate blood replacement, the use of intravenous Pitocin drip and, when indicated, hysterectomy.

The fact that only one death from abruptio placenta has been recorded during this five-year period is commendable. It is probable that this low figure is the result of a better understanding of the pathology of this condition, as well as a decrease in the incidence of toxemia of pregnancy with which it is so frequently associated. Again, adequate blood replacement is essential. One must also be on the lookout for afibrinogenemia.

One of the two patients who died as a result of placenta previa died following the vaginal delivery of the infant through a central placenta previa. If we are to effectively reduce maternal deaths from placenta previa, the dangers of such type of treatment must be realized and that cesarean section is the method of choice. Preparations must be made to administer large quantities of blood, having blood ready before needed. It must also be realized that examination of the patient without the proper precautions can result in devastating hemorrhage before effective treatment can be instituted. It is gratifying to be able to report that there were no deaths from ectopic pregnancy nor coagulation defects. Undoubtedly, these two conditions have occurred during this five-year period of time, but apparently have received effective therapy.

Infection and toxemia

Statistically, infection is a significant cause of maternal mortality in Montana, accounting for about one death out of five. Of the numbers succumbing to infection, 60 per cent were the result of septic abortion. The majority of these were the result of criminal attempts to empty the uterus. Obstetrics has shared fully with other branches of medicine and surgery from the benefits of antibacterial agents during the past 15 years. Maternal morbidity and mortality have shown a remarkable reduction because of the use of these drugs. Loss of life from infection would be relatively insignificant were it not for the fact that criminal abortions are performed in large numbers across the country, and frequently result in death or invalidism. It is important to remember that in order to be effective the organisms must be sensitive to particular antibiotics. Cultures and sensitivity tests should, therefore, be resorted to when indicated.

Toxemia of pregnancy accounted for only 8.7 per cent of the deaths during this five-year period. Further improvements in the care of these patients and in the reduction of the death rate from toxemia awaits the elucidation of the basic etiology of this condition. Advances in renal physiology, biochemistry, and pharmacology have increased proficiency in treating the symptoms of this disease. It is realized that the basic alteration in physiology is of arteriolar spasm associated with the metabolic disturbances of water and sodium retention. Treatment directed toward the relief of these two physiologic alterations has resulted in our ability to decrease the morbidity and mortality from toxemic pregnancy.

It is only in the past five to ten years that effective agents to combat vasoconstriction have been available. These agents are effective usually at one of three locations: central, ganglionic, or neuromuscular junction. Also, in the recent past the very effective oral diuretic agents, such as acetazolamide, chlorothiazide, and hydro-chlorothiazide have

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Mediastinal tumors

Hobart M. Proctor, M.D., Denver

Almost all mediastinal tumors are surgical problems, particularly for diagnosis. Predilection of each tumor for a certain compartment of the mediastinum is also helpful.

THE PRESENCE OF AN UNUSUAL MEDIASTINAL shadow on a chest film has, until recently, been of academic rather than surgical interest. Operative and anesthetic technics permitting access to the mediastinum has allowed this interest to be directed along therapeutic rather than esoteric lines. Tumors occurring in the mediastinum are now approached with the same operative aplomb as are tumors arising in the bronchi or lung parenchyma, and with generally better operative results.

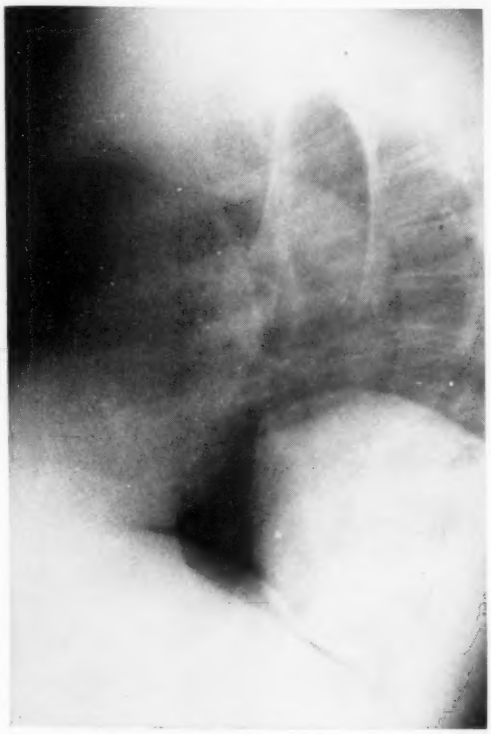

Fig. 1. Lateral chest film showing large neurilemoma occupying posterior-inferior mediastinal compartment. The tumor was easily removed by blunt dissection.

Anatomic relationships

The preoperative diagnosis of a mass occuring in the mediastinum is largely dependent on its location. Anatomically, the mediastinum is defined as that portion of the chest lying between the left and right pleural spaces; bounded superiorly by the thoracic inlet, inferiorly by the diaphragm, anteriorly by the sternum, and posteriorly by the bodies of the thoracic vertebrae. The heart and great vessels further subdivide the mediastinum into the anterior-superior and posterior-inferior compartments. Various mediastinal tumors have such a propensity for occupying a specific compartment that their radiographic localization is frequently diagnostic, or at least a myriad of possibilities can be narrowed to a few which further study will demarcate.

Nerve tumors

Most common of all tumors found within the mediastinum are those arising from the paravertebral sympathetic and intercostal nerves. Frequently arising from the nerve sheathes, they almost always are located in the posterior mediastinum near the intervertebral foramina (Fig. 1). The neoplastic mass may extend medially into the spinal canal and laterally into the retropleural space with a narrowed connection through the foramen, the so-called "dumbbell" tumor. Not infrequently, the neurilemoma or the neurofibroma will produce a radicular type pain along

the course of an intercostal nerve. This symptom, occurring in a patient with *cafe au lait* spots should suggest the diagnosis which chest roentgenography can then confirm. The operative management of these benign neurogenic tumors requires that they be simply shelled out from their retropleural beds with minimal surgical morbidity, and virtually no incidence of recurrence.

Ganglioneuroma, neurofibrosarcoma, and sympathicoblastoma represent the most frequently encountered malignant posterior mediastinal tumors. Radiographically, they do not present as well-defined borders as do the benign neurogenic tumors. Their early recognition and surgical excision supplemented by radiation therapy offer fair chance for cure[1]. Rarely, pheochromocytoma will occur within the posterior mediastinum and defy detection despite positive chemical evidence of their presence. The possibility of an intrathoracic location for a pheochromocytoma should not be overlooked when the diagnosis is a probability but the tumor cannot be demonstrated in the usual sites.

Cystic tumors

Occurring throughout the mediastinum, but most commonly located in the posterior-inferior compartment, are the bronchogenic and enterogenous cysts. These latter structures represent a situation similar to that found in reduplications of the gut at more distal levels. They arise from embryologic cysts within the esophageal wall and are lined with either the squamous cells of the esophageal mucosa, or the mucus-containing goblet cells of the stomach. These enterogenous cysts attain large dimensions early, and are frequently discovered in the first years of life because of progressive signs of respiratory embarrassment. Rarely do the esophageal cysts communicate with the lumen of the esophagus, but peptic ulceration of the cyst wall may perforate into an adjacent bronchus with fatal results as a consequence of tracheo-bronchial digestion by the cystic contents.

Bronchogenic cysts cause symptoms only through pressure or when they become infected through communication with the bronchial lumen. Lined with pseudo-statified, ciliated epithelium, they represent diverticula

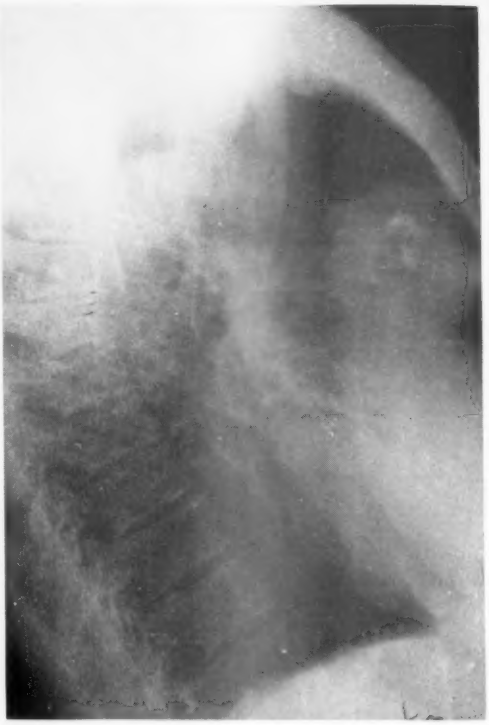

Fig. 2. Benign cystic teratoma in anterior mediastinal compartment. Note areas of calcification representing teeth. Diagnosis confirmed at operation.

of the tracheo-bronchial anlage. In this regard they may be considered extra lobes of the lung, and may occasionally possess a separate pleural space. These benign bronchogenic cysts are not infrequent findings on routine adult chest films. They should be surgically excised because their true identity can rarely be determined preoperatively.

Teratomata and thymomas

Teratomata and thymomas occupying the anterior mediastinal space are only slightly less frequent sources of diagnostic difficulties than are the neurogenic tumors. However, their malignant degeneration which frequently occurs would make an aggressive attitude regarding their early diagnosis and removal more important than with the neurogenic tumors. The pluripotential tissues of the teratoma evolve into both carcinomas and sarcomas with almost equal facility.

Benign teratomata are usually cystic, but

occasionally may contain teeth, cartilage, and hair which make their radiographic diagnosis much easier (Fig. 2). The multilocular cysts usually contain remnants of thymic tissue in their walls along with particularly well-differentiated foci of pancreatic tissue whose acinar and islet components contribute to the cystic nature of the teratomata, and could conceivably influence glucose metabolism[3].

The malignant teratomata invade early in their course and produce death by encroachment on the vital structures in the immediate vicinity. Frequently they are indistinguishable from choriocarcinoma and seminomas whose teratomatous origin can only be inferred. The comparative sensitivity of these tumors, especially the seminomas, to radiation therapy makes the correct diagnosis by excisional biopsy of the utmost importance[7].

The relationship between the thymus and teratomata is not clear, but that the former is an anlage of the latter is a distinct possibility. All of the malignant variations usually ascribed to mediastinal teratomata also could have arisen from the totipotential epithelial cells of the thymus[2,9].

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Modern concepts in environmental medicine*

Franklin D. Yoder, M.D., Chicago

A comprehensive statement of the new Division of Environmental Medicine recently formed by the A.M.A. Frank Yoder, author of this paper, is a native of Wyoming. He served as Director of the Wyoming Department of Public Health and as the Wyoming Editor of the Rocky Mountain Medical Journal. His friends in this area will recognize the scholarship and serious consideration he has given this important study for our information.

THE ORGANIZATION AND OPERATION of the A.M.A. offices in Chicago have been redesigned so that all of the councils, bureaus and committees have been aligned with departments, and these have been logically grouped into seven divisions. These are the Divisions of Business, Communications, Field Service, Legal and Socio-Economic, Scientific Activities, Scientific Publications, and Environmental Medicine. It is the last of these—Environmental Medicine—with which I am associated, as Director.

Division of Environmental Medicine—A.M.A.

Most of these division names are self-explanatory, but this is not entirely true for the Division of Environmental Medicine. So, because of your interest in A.M.A., and also because I am a friend and former neighbor, you may be interested in knowing about the variety of programs with which we are concerned in the Division of Environmental Medicine.

We have the Department of Health Education, an important area for transmission of general health information to the public.

*Presented for Dr. Yoder by Donald A. Dukelow, M.D., Medical Consultant, Department of Health Education, Division of Environmental Medicine, American Medical Association, to the Wyoming State Medical Society, Moran, Wyoming, September 8, 1960.

The chief mission of the department is to interpret health advances and sensible living practices to the public and to motivate their proper application. Included is interpretation of the medical profession to the public, and doctors and patients to each other. It conducts an answering service for the questions of laymen, serves as staff for the A.M.A. Committee on the Medical Aspects of Sports and the Joint Committee on Health Problems in Education of the National Education Association and the A.M.A. Its promotion of good school health practice includes conduct of the National Conference on Physicians and Schools.

The Department of National Security initiates, develops and implements programs involving the medical and health aspects of national security. It furnishes staff assistance to the Council on National Security and its committees and provides them assistance and guidance in formulating programs and policies with respect to military medical affairs, medical disaster preparedness, and other matters involving medical and health problems and activities in national security.

The Department of Occupational Health serves as staff to the Council on Occupational Health. The council promotes the protection and improvement of the health of the working population. It advocates medical examination and supervision of all workers for suitable job placement, health maintenance through health education, periodic examination and care of occupational disabilities, and control of hazards in the work environment. Areas of interest and activity include workmen's compensation, rehabilitation, employment of the handicapped, vision and hearing conservation, and investigation and control of health hazards of industry. The council provides leadership in the teaching of occupational medicine at all levels of medical education. It encourages and assists physicians in other fields of practice to learn more about the health of the worker in relation to his job. The council also serves, on behalf of the A.M.A., to develop in aerospace medicine the most effective medical leadership and contributions possible.

The Department of Rural Health serves the Council on Rural Health by encouraging constituent organizations to activate rural health committees within their organizations, and by distributing information on rural health matters, especially methods and technics of community leadership and organization. It promotes self-analysis surveys to find out what local people feel are their chief health problems, encourages counseling between interested farm and rural groups, and promotes regional, state and county rural health conferences. One of its chief endeavors in recent years has been to aid rural communities in securing physicians.

We have Medical Liaison Representatives in the A.M.A.'s Washington office who establish and maintain liaison with federal, professional, and voluntary health agencies and organizations, report relevant information to A.M.A. headquarters and, when it is of mutual interest and appropriate, to other health agencies and organizations. Authorized but not yet implemented within this division are Departments of Community Health and International Health.

These, then, are the activities within A.M.A.'s Division of Environmental Medicine, and you probably will agree that they constitute a broad range of functions. Yet, the term environmental medicine, in its broadest sense, could be even more inclusive. We might think of it on one hand as beginning with the biologic, chemical, physical and social aspects of medicine as they apply to extremes of the three dimensions and perhaps even to the fourth dimension in the vast, yawning areas of outer space and, on the other hand, the atom in body cells consisting of a nucleus surrounded by a cloud of orbiting electrons. At the cell level proceeds the struggle for survival upon which all life is based.

Historical background

The physician historically has been involved with the body and its environment[1]. Patients always have expected their doctors to be omniscient. Some physicians thought that they had to live up to these expectations and pretended to know more than they actually did. Today medicine is compartmented into many specialties, though still based on the general practice of medicine. Whether

specialist or general practitioner, today's physician must have interest in the environment of man.

There is so much yet to learn about so many things which surround us. In this increasingly radioactive environment with polluted air, ensewaged water, contaminated foods and hazardous occupations, how to live usefully and happily in greater crowds, at greater speeds and with more enduring handicaps becomes a problem[2]. It has been suggested that new forms of microorganisms introduced from outer space may produce the most pervasive infections yet known on the face of this earth. Just as we once fought with a new antibiotic a strain of organisms resistant to known antibiotics, we may have to utilize our new technologic developments, such as radioactive isotopes, to help us survive our twentieth century alchemy.

Time axes are basic periods during which the seeds of medical progress are planted leading to tremendous leaps in science[3]. Among such time axes in medicine we distinguish: Hippocratic medicine, which was naturalistic and observational; the liturgical, psychotherapeutic and hypnotic cults of Aesculapius; the school of Alexandria; Galen; Vesalius; Paracelsus; Harvey and the experimental methods; and Thomas Addison marking the origin of modern endocrinology.

The time axis introduced by Addison's first report on the adrenal gland has seen more than a century of intensive discovery and exploitation in a myriad of sciences—endocrinology, bacteriology, virology, physical and biological chemistry and physics. This time axis may see the virtual control of both internal and external environment.

Preventive medicine

Within our broad definition of environmental medicine, there are a great variety of factors that should be considered. Among these, the field of preventive medicine unquestionably is assuming increasing significance. What has preventive medicine to offer the physician in private practice?

This term should be explained immediately because it means so many things to different people. The object of all medical practice is to prevent disease. The virtue of preventive medicine lies in its concentration of our attention on the maintenance of health and the prevention of disease. Haven Emerson has said, "The best way to correct many of the current failures of our social order, to prevent disease and give humane care to the sick, is to take part in community agencies, contribute time and interest to any one of a multitude of public services (health departments) and learn by sharing in the problems of the officers of government. Medicine increasingly becomes a bridge between what actually occurs and what can be done to raise the level of social performance. Every physician owes it to his patients to see that they know and share in the local social resources intended to stop wasteful overflow of disease and build up a reservoir of community health as an indispensable background for individual and family health. Neither the state nor any device of insurance can create that security of health which depends on the way of life we make for ourselves and our neighbors."[4] These remarks of Dr. Emerson merit careful consideration.

Foods and nutrition

If one were asked to select the single most important environmental factor relating to health, foods and nutrition would be a likely choice. We distinguish between these terms by thinking of foods as the substances we take into our bodies and nutrition as what happens to these substances after we have eaten them.

Nutrition authorities agree that the best way to obtain proteins, vitamins and minerals is in the food we eat—vegetables, fruits, milk and milk products, eggs, meat, fish and whole grain or enriched bread and cereals. The usual American diet now includes such a variety of foods that most persons can hardly fail to have an ample supply of the essential food constituents. It becomes the physician's responsibility to provide guidance for the public in obtaining nutrients from foods and avoiding self-medication with multivitamin preparations for those conditions that only a physician is competent to recognize and treat.

There is, in fact, a need for increased and improved education in nutrition directed to

the medical student. Since nutrition, and the selection of foods for its proper maintenance, is such an important aspect of environmental medicine, the physician who has the responsibility for maintaining the health of the family and the community must be willing, as well as able, to accept the responsibility to guide and interpret food use in an authoritative manner.

The A.M.A.'s Council on Foods and Nutrition has developed symposia around current controversial topics in human nutrition as a part of a physician education program in nutrition. These symposia are planned for the general practitioner and are conducted in cooperation with a host medical school and local medical societies. Three were planned for 1960, one on tooth formation and dental caries, in Massachusetts; a general session during the Annual Meeting of the A.M.A. in Miami, Florida, and a symposium during the Clinical Session of the A.M.A. in Washington, D. C., to explore the clinical signs of nutrient deficiencies.

Food additives

There is need for the physician to understand the consumer's point of view in studying the many new additives to food. We can best understand why additives are used, the benefits derived from them, and the meaning of some of the terms used in speaking of them, by considering some of the important classes of additives and an example of each.

CLASSES OF ADDITIVES

A. Nutrient supplements—thiamine added to bread.

B. Non-nutritive sweeteners—sugar substitutes.

C. Preservatives—antimycotic agents in bread.

D. Emulsifiers or "surface active agents"—lecithin.

E. Stabilizers and thickeners—carboxy methyl cellulose, propyl esters and alginic acid.

F. Acids, alkalies, buffers, neutralizing agents —the acetate buffers in corn syrups.

G. Flavoring agents—ethyl butyrate, fruity flavors, in candy.

H. Bleaching agents—aging and bleaching of flour.

SPECIAL CLASSES OF ADDITIVES

A. Pesticides (The Miller Amendment of 1954 establishes safe limits for residues of pesticides on fruits and vegetables).

B. Coal tar colors (The color used for food must be on a list of colors approved by F.D.A. as harmless and suitable for use).

LABEL DECLARATION OF FOOD ADDITIVES

Most consumers know that the law contains a general requirement that food ingredients be named on the label. Many of the chemicals named above, however, will not be found on the list of ingredients[5].

The Council on Foods and Nutrition[6] has reported that: "For foods for which legal standards of identity have been established and that have no optional ingredients, the listing of the ingredients on the label is not required under federal law. A general statement to the effect that the product conforms to all applicable federal and state food standards is deemed sufficient. When the standards allow optional ingredients, however, the Federal Food, Drug and Cosmetic Act states, 'In prescribing a definition and standard of identity for any food or class of food in which optional ingredients are permitted, the Secretary shall, for the purpose of promoting honest and fair dealing in the interest of consumers, designate the optional ingredients which shall be named on the label.'" (Section 401)

A list of all ingredients on the label can be of considerable importance to a consumer who is subject to food allergies or some other abnormal condition and who has trained himself to read all labels carefully. It is, therefore, in the interest of both the food processor and the consumer that all label information of foods be properly informative and complete.

Carcinogens

The Delaney Amendment to the Federal Food, Drug and Cosmetic Act states that no tolerance may be set for additives that produce cancer when fed to man or animal. One of these, you will recall, was the controversy last fall in the cranberry episode (aminotriazole).

The American Medical Association, through its Council on Foods and Nutrition and the Council on Legislative Activities, is beginning a study of food additives legislation because of recent rather curious developments[7].

As a generalization, it may be stated that ionizing radiation can produce cancer in exposed tissues. Consequently, any food product that contains any added radioactive isotope would be considered undesirable under the Delaney Amendment. Therefore, if there is any induced radiation resulting from preservation of food by irradiation, the Food and Drug Administration will not issue a label

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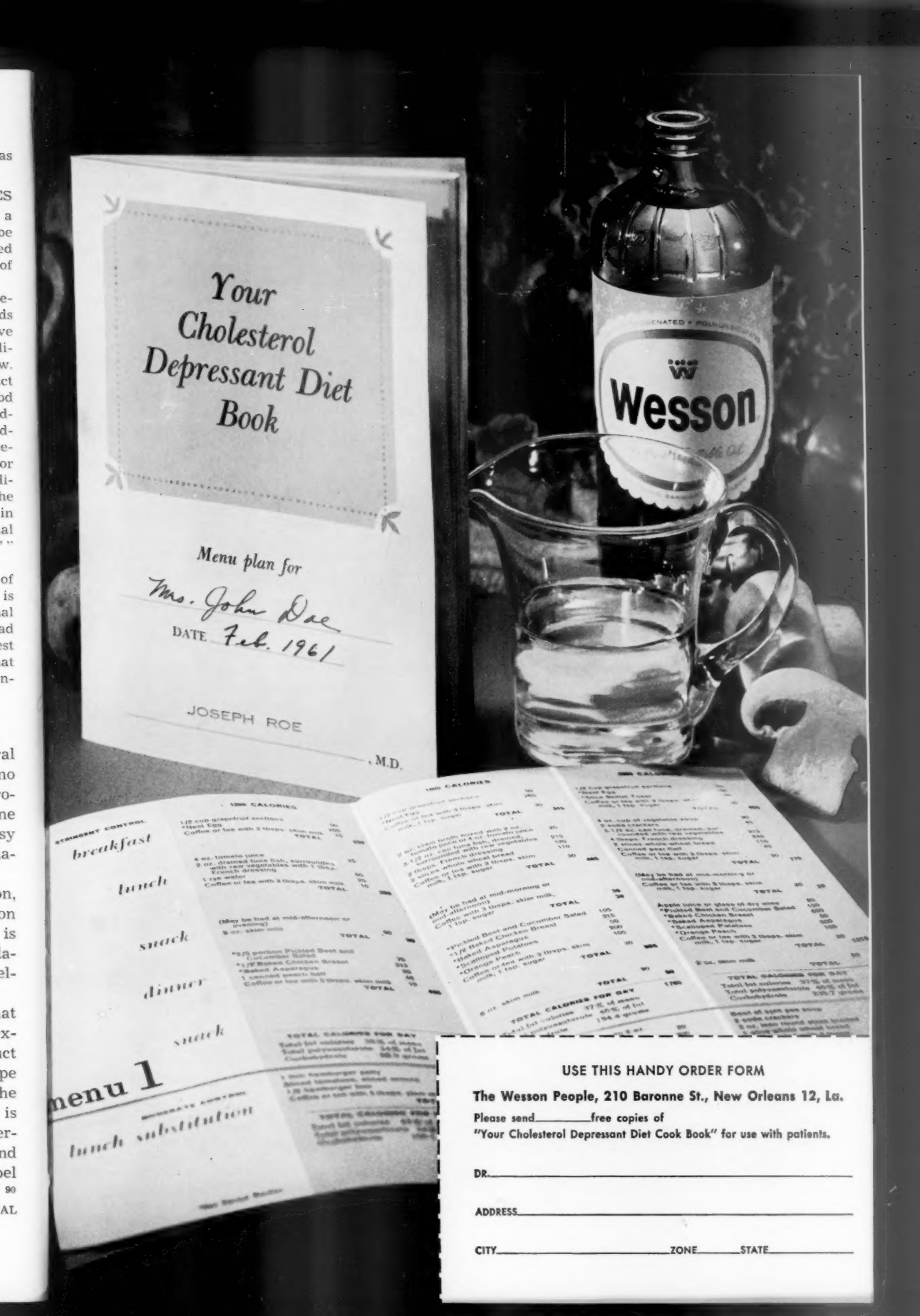

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THE WASHINGTON SCENE

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

The American Medical Association supported the Kennedy Administration's proposal to provide $750 million in matching funds for construction of medical, dental, public health and osteopathic schools.

In a letter to Sen. Lester Hill (D., Ala.), Chairman of the Senate Labor and Public Welfare Committee, Dr. F. J. L. Blasingame, Executive Vice President of the A.M.A., said:

"As an association of 179,000 practicing physicians, we are vitally interested in maintaining the high quality of medical education in the United States because of its direct relationship to medical care. For over a century, the American Medical Association has been actively and effectively engaged in the improvement of medical education in the United States. It can now be said, with assurance, that medical education in this country is superior to that found anywhere else in the world. It is not a coincidence that the improved standards of medical care in the last half century saw the elimination of substandard medical schools and diploma mills which had been turning out graduates in large numbers. This improvement in medical education is the result of the vigorous efforts of this association and other interested organizations.

"We strongly believe that increased attention must be given to the adequacy of physical facilities, the availability of qualified instructors and the availability of teaching material and patients for the clinical phases of medical education if high standards of medical education are to be maintained. Any attempt to increase the number of medical students without regard to these conditions will result in a lowering of the standard of medical education. We are of the firm conviction that increase in the physical facilities available for medical education should be given priority at this time over any other federal legislation in the field of medical education.

"We believe that there is need for assistance in the expansion, construction and remodeling of the physical facilities of medical schools and, therefore, a one-time expenditure of federal funds on a matching basis, where maximum freedom of the school from federal control is assured, is justified."

The A.M.A. opposed a provision that might encourage medical schools to expand too rapidly. Dr. Blasingame said: "It is quite possible that a forced increase in freshman enrollment would be detrimental to the quality of medical education."

The association didn't take a position on the provision of the Administration legislation that would provide federal scholarships to medical students. However, Dr. Blasingame described to the senate committee A.M.A.'s new medical scholarship and student loan programs.

The General Accounting Office found the Defense Department's Medicare program being conducted generally "in a satisfactory manner," but recommended some changes designed to correct what it considered "important deficiencies."

The Army, which administers the program of medical care for dependents of members of the armed services, took steps to put into effect most of the recommendations of the GAO, which audits federal spending for Congress.

However, Medicare officials rejected a GAO proposal for a change in physician fees.

"Our review disclosed that physicians' claims for medical care are, in general, significantly higher in states where maximum fees are made known to physicians than in those states where maximum fees are not made known," the GAO reported. "We estimate that there is an additional cost of as much as $3 million to $4 million annually as a result of maximum fees, rather than normal fees, being charged in the states where fee schedules are distributed to the physicians."

The GAO recommended that lower fixed fee schedules be negotiated for states where a high percentage of physicians' claims are for maximum allowable fees, "subject to being raised only on the basis of clearly supported evidence of higher normal fees."

If lower fees cannot be negotiated, the GAO said, efforts should be made "to have the state medical society or other appropriate parties accept the responsibility for determining that physician claims are generally not in excess of their normal charges."

The GAO further recommended that "physicians be required to certify on each claim that the amount billed does not exceed the physician's normal fee for the medical care furnished."

The Army disagreed, saying that it believed "the present contracting concept is the most suitable to meet the requirements and is in the best interests of the government."

The A.M.A. noted that it had held from the outset that "fixed fee schedules would result in a more expensive program than if physicians were permitted to charge their normal fees."

Fixed fee schedules call for some fees above some so-called normal fees and others below average fees, the A.M.A. said, "physicians tend to 'balance out' by using fees listed in the fixed fee schedule."

Medicare was started a little over four years ago. During the first four years of the program, $130 million was paid to civilian doctors and $133 million to civilian hospitals for care of 1.1 million military dependents. Maternity cases accounted for about half the total.

Medicare has asked Congress for $73.2 million for the fiscal year 1962 beginning this July 1. This is a $6.9 million increase over Medicare's current budget. The increase is needed, Medicare said, because of more military dependents eligible for the program's benefits and increases in the costs of services.

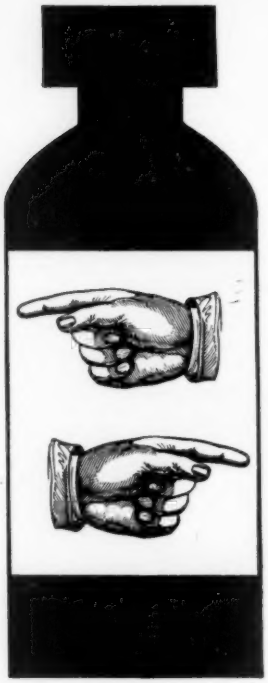
Potpourri cont. from page 8

talents of a child must be assets to his friends, never claims to distinction from his friends. Americans have become obsessed with the 'cult of earliness.' The baby who cuts the first tooth and the child who learns to read first are highly praised. It would be well to remember that the word precocious comes from a Greek word meaning 'too soon done.' It is the teacher's responsibility to protect children from being picked 'too green.' Too often in schools, excessive adulation is given to early maturers. The high school athlete is praised because he 'got bigger sooner'." Howard Lane: California ACE News, May, 1959.

13. "In gross left ventricular enlargement, particularly with aortic incompetence, you can of course get a rumbling diastolic murmur of the Austin Flint type. And even without aortic incompetence big left ventricles can sometimes give a rumbling sound as blood flows in from the antrium. If there is gross mitral incompetence the large inflow from the atrium gives a mitral diastolic rumble." McMichael, J., and others: Clinicopathological Conference: A Case of Malignant Hypertension, Brit. M.J. **1**:262 (Jan. 23) 1960.

14. "The influence of posture is related to two phenomena: (1) the minute output of the heart increases in recumbency, and (2) the heart rate slows in this position. As a result the stroke output is very considerably increased in recumbency. Other things being equal, this tends to increase the intensity of systolic basal murmurs." Questions and Comments: Basal Systolic Murmurs in Children When the Patient Is Lying Down, Brit. M.J. **1**:291 (Jan. 23) 1960.

Trademarked drugs . . .



or "drugs anonymous"?

In the field of medicine, as almost everywhere else in a free economy, the trademark concept has evolved over the years. As with most human institutions, there are some who may not consider it ideal; but it has brought about three signal benefits:

To the physician it gives assurance of quality in the drugs he prescribes—assurance backed by the biggest asset of the maker, his reputation.

To the manufacturer it gives one of the greatest possible incentives to produce new and better curative agents.

To the pharmacist it gives preparations which he can dispense with confidence.

If trademarks are done away with, a whole new setup must be created:

1. An enormously expanded, expensive system of government quality control.

2. A new system of generic nomenclature which would magically turn out names not only rememberably simple, but also conforming to the principles of complex chemical terminology.

3. Something new to fill the gap left by the elimination of the trademark incentive to produce new and better drugs.

The American system has been pre-eminent in producing and distributing good medicines. Above all it has been successful in creating new advances in therapy. In a dubious effort to provide cheaper medicines by abolishing the trade names upon which the responsible makers stake their reputations, let us beware of sacrificing this success.

This message is brought to you on behalf of the producers of prescription drugs to help you answer your patients' questions on this current medical topic. For additional information, please write **Pharmaceutical Manufacturers Association,** *1411 K Street, N. W., Washington 5, D.C.*

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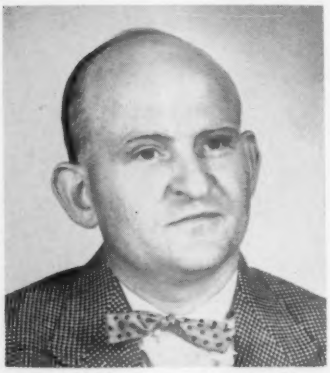

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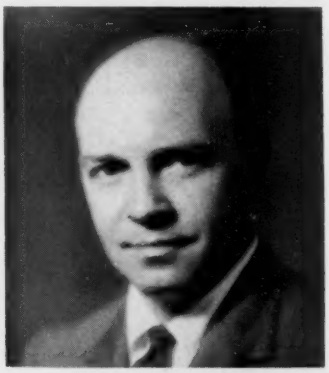

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The Rocky Mountain Medical Conference

What It Is — What It Does

The Rocky Mountain Medical Conference is a biennial conference, a self-sustaining joint enterprise of six state medical societies. It was first suggested in 1935 by Dr. George P. Lingenfelter, Colorado's fraternal delegate to New Mexico, Utah, and Wyoming. Colorado, Utah, and Wyoming jointly decided to undertake such a conference, and New Mexico joined within a year. The first meeting was held in 1937 in Denver, with the Colorado Society as host. At that meeting permanent policies were fixed for the future of the Conference, and these policies have been adhered to ever since. Montana joined the Conference in 1939 at the time of the second meeting in Salt Lake City. Nevada joined in 1959.

The basic principle and sole purpose of the Conference is to meet every two years to bring Rocky Mountain physicians together for an outstanding scientific program —and to bring them together for renewal of their regional friendships. The scientific program features speakers of national stature from outside the Rocky Mountain Region, and the meeting place of the Conference is rotated among the participating states. The Conference *does not* elect officers, indulge in medical politics, consider any resolutions or pronouncements relating to the policies of organized medicine, and forbids itself any activities that would aggrandize an individual, state or locality.

Management of the Conference is vested in a "Continuing Committee." Each participating State Medical Society has organized a Conference Committee of five of its members, serving overlapping five-year terms. These committees, together, constitute the Continuing Committee, which meets at least annually to plan future programs and manage the affairs of the Conference. The chairman of the host state's Conference Committee is Chairman of the Conference to be held in that state. He selects a Secretary-Treasurer for that particular meeting and with the help of the Continuing Committee also selects any subcommittees that may be needed to plan the meeting for which his state is host.

Originally, the Rocky Mountain Medical Conference met at times separate and distinct from the annual sessions of the participating states. In the years since World War II, with an ever increasing number of medical meetings, it has become customary for the host state to merge its own "state meeting" with the Conference and conduct the Conference at the season usually reserved for its own meeting.

REGISTRATION AT R.M.M.C.

Registration at the Rocky Mountain Medical Conference is open to any Doctor of Medicine. Registration is not limited to physicians within the six states which participate in managing the Conference.

There is no registration fee for the 11th meeting of the Conference at Salt Lake. Each physician will be given an identification badge, and admission to all Conference activities will be by badge only. Separate tickets will be on sale at the registration desk for the banquet.

The R.M.M.C Runs by the Clock!

The Scientific Programs of the Rocky Mountain Medical Conference are run by the clock, to the minute. This has been true of the previous meetings, and it will be true this September.

All meetings will begin on time, all speakers will be required to begin their presentations exactly on time and none will be permitted to speak longer than as scheduled in the program.

All who attend the Conference are requested to assist the speakers and benefit themselves by being in the meeting room a few minutes in advance of the papers they wish to hear. Any member who arrives late to hear any particular paper is assured that he will miss part of that paper! Also, his late arrival would be disturbing to the speaker and the audience alike.

Hotel Reservations

Headquarters for the Conference will be the Hotel Utah and the Hotel Utah Motor Lodge. Both have set aside blocks of rooms to accommodate doctors and their families attending the Rocky Mountain Medical Conference. Reservations for the Conference should be made directly to the Hotel or Motor Lodge.

Pocket Program

A final program for the 11th Rocky Mountain Medical Conference, complete with additional details not available for the Program Number of the Journal, will be published in pocket size in August and mailed to all members of the participating State Medical Societies.

Entertainment

The President's Reception and Banquet is scheduled for Thursday evening, September 14. This will be the social highlight of the Conference. The annual Dinner Meeting for stockholders of the Medical Service Bureau (Blue Shield) is scheduled for Wednesday, September 13. Special Luncheons will be held September 13, 14, 15, 1961.

President's Banquet

A President's Banquet has been arranged for all attending the R.M.M.C., which will be held in the Lafayette Ballroom of the Hotel Utah. Excellent entertainment will be presented and will be highlighted by a speaker of national prominence. Social hour will be at 6:30 p.m. and dinner will be at 7:15 p.m.

Woman's Auxiliary Program

A Hospitality Hour will be held in the President's Suite of the Hotel Utah Thursday, September 14. Also scheduled for Thursday will be a Luncheon to be held at the Alta Club at 1:00 p.m.

A brunch will be held on Friday, September 15, at the Cottonwood Club. Honored Guest will be Mrs. Harlan English, President-Elect, Woman's Auxiliary, American Medical Association.

PROGRAM

SIXTY-SIXTH ANNUAL SCIENTIFIC SESSIONS

of the Utah State Medical Association in Conjunction With the

ROCKY MOUNTAIN MEDICAL CONFERENCE

September 13, 14, 15, 1961

Hotel Utah Motor Lodge

Wednesday Session—September 13

Morning

8:00 a.m.—Registration—(all day)

8:50 a.m.—Welcome Address—Wallace S. Brooke, M.D., President, Utah State Medical Association, Salt Lake City, Utah

Presiding: Wallace S. Brooke, M.D., President, Utah State Medical Association, Salt Lake City, Utah.

9:00 a.m.—"ACTH, Cortisone and the Concept of Potassium Deficiency," Donald W. Seldin, M.D., Department of Internal Medicine, The University of Texas Southwestern, Dallas, Texas.

9:30 a.m.—"Genetics, Biochemistry and Medicine, Part I," Barton Childs, M.D., Associate Professor of Pediatrics, The Johns Hopkins Hospital, Baltimore, Maryland

10:00 a.m.—"The Newer Progestational Agents," Willard M. Allen, M.D., Department of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, Missouri

10:30 a.m.—Recess to visit exhibits

11:00 a.m. (Check your official program)—Robert Arthur Bruce, M.D., Department of Medicine, University of Washington, Seattle, Washington.

11:30 a.m.—"Alcoholism and the Nervous System," Leonard W. Jarcho, M.D., Associate Professor of Medicine, University of Utah, Salt Lake City, Utah

12:10 p.m.—Luncheon, Empire Room, Hotel Utah. Chairman: M. M. Wintrobe, M.D., University of Utah College of Medicine

Guest Speaker: Donald W. Seldin, M.D., Department of Internal Medicine, University of Texas Southwestern Medical School, Dallas, Texas

Afternoon

Presiding: Frank H. Tyler, M.D., University of Utah College of Medicine, Salt Lake City, Utah

2:00 p.m. (Check your official program).

2:30 p.m.—"Some Radiographic Features of the Newborn Chest," John Caffey, M.D., College of Medicine, University of Utah, Department of Pediatrics, Salt Lake City, Utah

3:00 p.m.—Recess to visit exhibits

3:30 p.m.—"The Modern Treatment of Cerebrovascular Disease," Leonard Jarcho, M.D.

4:00 p.m.—"The Pathogenesis and Treatment of Cerebral Hyponatremia," Donald W. Seldin, M.D.

Evening

6:00 p.m.—Blue Shield Reception—"House of Friendship," Prudential Federal Savings and Loan Auditorium, 3300 South State Street, Salt Lake City, Utah

7:00 p.m.—Annual Dinner Meeting, Blue Shield Stockholders, Prudential Federal Savings and Loan Auditorium

Chairman: Paul A. Clayton, M.D., President, Medical Services Bureau (Blue Shield)

Thursday Session—September 14

Morning

Registration—(all day)

Presiding: Cyrus W. Anderson, M.D., President, Colorado State Medical Society

9:00 a.m.—"The Stein-Leventhal Syndrome," Willard M. Allen, M.D.

9:30 a.m.—Howard L. Wilder, M.D., Department of Ophthalmology, Illinois Eye and Ear Infirmary, Chicago, Illinois

10:00 a.m.—"Genetics, Biochemistry and Medicine, Part II," Barton Childs, M.D.

10:30 a.m.—Recess to visit exhibits

11:00 a.m.—Symposium, "Care of the Inoperable Breast Cancer Patient," sponsored by Staff of the Holy Cross Hospital, Salt Lake City, Utah

Moderator: L. Wayland MacFarlane, M.D., Internal Medicine

Members: Wallace S. Brooke, M.D., Surgeon; A. L. Karavitis, M.D., Neuro-Surgeon; Ralph R. Meyer, M.D., Radiologist; Jack L. Tedrow, M.D., Psychologist and Neurologist

12:10 p.m.—Luncheon, Junior Ballroom, Hotel Utah

Chairman: Irwin H. Kaiser, M.D., Department of Obstetrics and Gynecology, University of Utah College of Medicine, Salt Lake City, Utah

Guest Speaker: Willard M. Allen, M.D., Department of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, Missouri

Afternoon

Presiding: Carter M. Ballinger, M.D., University of Utah College of Medicine, Salt Lake City, Utah

2:00 p.m.—Prize-winning scientific paper by a University of Utah medical student

2:15 p.m.—Prize-winning scientific paper by a University of Utah medical student

2:30 p.m.—Study Sessions by the Various Specialty Groups—Scientific Movies

These study sessions will be conducted on the basis of relative informality. Anyone is invited to attend the study session of his choice, but the attendance will be limited in direct accordance to the size of the room (first come, first served, etc.). The study sessions are scheduled from 2:30 to 4:30 p.m., and the scientific movies will be shown concurrently.

Evening

6:00-7:15 p.m.—President's Reception, Empire Room, Hotel Utah

Honoring: Julian P. Price, M.D., Chairman, Board of Trustees, American Medical Association; Wallace S. Brooke, M.D., President, Utah State Medical Association; Ralph E. Jorgenson, M.D., President-Elect, Utah State Medical Association

7:30 p.m.—President's Banquet, Lafayette Ballroom, Hotel Utah

Presiding: Wallace S. Brooke, M.D., President, Utah State Medical Association

Honored Guest and Speaker: Julian P. Price, M.D., Chairman, Board of Trustees, American Medical Association, Chicago, Illinois

Featured Speaker: Howard K. Smith, Columbia Broadcasting System, Washington, D. C.

Friday Session—September 15

Morning

Registration—(all day)

Presiding: Nevada State Medical Association Officer

9:00 a.m.—"Malignant Melanoma, Surgical and Chemotherapeutic Management," John S. Stehlin, Jr., M.D., Assistant Professor of Surgery, University of Texas, Postgraduate School of Medicine, Houston, Texas

9:30 a.m.—"The Surgical Treatment of Primary Skeletal Tumors," C. Howard Hatcher, M.D., Professor and Head, Division of Orthopedic Surgery, Department of Surgery, Stanford University School of Medicine, Palo Alto, California

10:00 a.m.—"Etiology of Pancreatitis, Clinical Experiences in Management of 375 Patients," John M. Howard, M.D., Professor of Surgery, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania

10:30 a.m.—Recess to visit exhibits

11:00 a.m.—Howard L. Wilder, M.D.

11:30 a.m.—"Variations in the Growing Skull Which Simulate Fractures," John Caffey, M.D.

12:10 p.m.—Luncheon, Empire Room, Hotel Utah.

Chairman: Philip B. Price, M.D., Dean, College of Medicine, University of Utah, Salt Lake City, Utah

Speaker: John M. Howard, M.D., Professor of Surgery, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania

Afternoon

Presiding: Walter J. Burdette, M.D., University of Utah College of Medicine, Salt Lake City, Utah

2:00 p.m.—"Osteoid Osteoma of the Spine," C. Howard Hatcher, M.D.

2:30 p.m.—"Studies of Shock and Resuscitation," John M. Howard, M.D.

3:00 p.m.—"Soft Tissue Sarcomas—Clinical Management," John S. Stehlin, Jr., M.D.

3:30 p.m.—Recess to visit exhibits

4:00 p.m.—Civil Defense Program

Scientific Exhibitors

American Medical Association Council on Food and Nutrition

Utah Department of Health and Heart Association—George L. Veasy, M.D.

Rumel Chest Clinic and Department of Radiology —George L. Veasy, M.D.

"What goes on"—Miss Virginia Pullen

American Association of Physicians and Surgeons —Everett B. Muir, M.D.

Utah Division, American Cancer Society—Mr. Wallace F. Toronto

St. Marks Hospital-Dept. of Pathology—Shelley A. Swift, M.D.

Medical Library, University of Utah—Mr. Robert Divett

Technical Exhibitors

Abbott Laboratories
Aloe, A. S., Co.
American Sterilizer Co.
Ames Company
Audio Digest
Ayerst Laboratories
Baker Laboratories
Baxter, Don, Co.
Beltone, Utah Co.
Boyle and Co.
Breon, George A., and Co.
Burroughs Wellcome and Co.
Carnation Company
Ciba Pharmaceutical Products, Inc.
Coca-Cola Company
Dairy Council of Utah
Deseret Pharmaceutical Co.
Desitin Chemical Co.
Doctor and Hospital Supply
Doho Chemical Corp.
Eaton Laboratories
Endo Laboratories, Inc.
Geigy Pharmaceuticals
General Electric
Intermountain X-Ray
Jazuzzi Whirlpool Bath
Knoll Pharmaceutical Co.
Lederle Laboratories
Lilly, Eli, and Co.
Lloyd Brothers, Inc.
Loma Linda Food Co.
Massengill, S. E., and Co.
Maico Corp. Hearing Aid
McNeil Laboratories, Inc.
Mead Johnson and Co.
Medical-Dental Mgmt. Corp.
Medical Service Bureau
Medco Co., J. A. Hippen
Meeker Products
Merck Sharp and Dohme
Mutual Benefit Life Ins. Co.
Nathenson, Si, P. R.
National Cash Register
National Drug Co.
Organon, Inc.
Ortho Pharmaceutical Co.
Parke Davis and Co.
Pepsi Cola Co.
Picker X-Ray
Pfizer, Charles, Laboratories
Physicians Supply Co.
Professional Life and Casualty
Riker Laboratories, Inc.
Robins, A. H., Co.
Roche Laboratories
Roerig, J. B., and Co.
Rorer, W. H., Inc.
Ross Laboratories
Sandoz Pharmaceuticals, Inc.
Saunders, W. B.
Schering Corporation
Schmid, Julius, Inc.
Searle, G. D., and Co.
Shadel Hospital
Smith Kline and French
Squibb, E. R., and Sons
Stacey, J. W., Inc.
Strasenburgh, R. J.
Stuart Company
Surgical Supply Center
Upjohn, The, Co.
Vaponefrin Company
U. S. Vitamin Pharm. Corp.
Warner-Chilcott Laboratories
Warren-Teed Products
Westinghouse X-Ray
Winthrop Laboratories

Rocky Mountain Medical Conference Continuing Committees

COLORADO: George P. Lingenfelter, M.D., Chairman, Denver; William M. Covode, M.D., Denver; H. Harper Kerr, M.D., Pueblo; Victor Crumbaker, M.D., Grand Junction; Frank J. Gorishek, M.D., Denver.

MONTANA: Dean C. Epler, M.D., Chairman, Bozeman; John R. Burgess, M.D., Helena; Herbert T. Caraway, M.D., Billings; John A. Layne, M.D., Great Falls; Stephen N. Preston, M.D., Missoula.

NEVADA: Thomas S. White, M.D., Chairman, Boulder City; Harold L. Boyer, M.D., Las Vegas; Willard P. McCormick, M.D., Reno; George A. Miners, M.D., Henderson; William M. Tappan, M.D., Reno; Adrien Ver Brugghen, M.D., Las Vegas.

NEW MEXICO: Aaron Margulis, M.D. (deceased —no replacement as yet); Wesley Connor, M.D., Albuquerque; Andrew Babey, M.D., Las Cruces; Charles Beeson, M.D., Albuquerque; V. E. Berchtold, M.D., Santa Fe.

UTAH: R. N. Hirst, M.D., Chairman, Ogden; Kenneth A. Crockett, M.D., Salt Lake City; T. E. Robinson, M.D., Salt Lake City; C. Hilman Castle, M.D., Salt Lake City; George H. Curtis, M.D., Salt Lake City.

WYOMING: Frederick H. Haigler, M.D., Chairman, Casper; Paul R. Yedinak, M.D., Rock Springs; Virgil L. Thorpe, M.D., Newcastle; J. S. Hellewell, M.D., Evanston; James W. Barber, M.D., Cheyenne.

Scientific Program Committee

John F. Waldo, M.D., Chairman; Carter M. Ballinger, M.D.;
Don B. McAffee, M.D.; Rulon F. Howe, M.D.;
C. Hilmon Castle, M.D.; William G. Dixon, M.D.

Woman's Auxiliary Committee

Mrs. Frank F. Daughters, Chairman.

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Supplied: FULVICIN Tablets (scored), 500 mg., in bottles of 20 and 100; 250 mg., in bottles of 30, 100 and 500. *Reference:* Sulzberger, M. B., *et al.*: Dermatology: Diagnosis and Treatment, ed. 2, Chicago, Year Book Publishers, 1961, p. 350. For complete details, consult latest Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, N. J.

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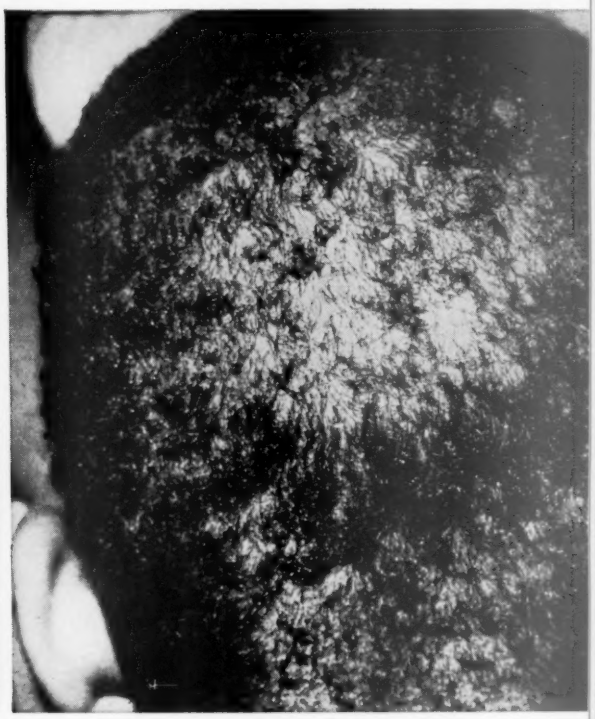
***Tinea capitis due to* T. tonsurans *cleared after 7 weeks of therapy with* FULVICIN.**

FROM WEINER, M. A.; GOULD, A. H., AND GANT, J. O., JR.: GRISEOFULVIN IN RINGWORM INFECTIONS. SCIENTIFIC EXHIBIT PRESENTED AT A.M.A. CLINICAL MEETING, DECEMBER, 1960, WASHINGTON, D. C.



Obituary

Dillon doctor dies suddenly

Dr. Harry Rasor of Dillon, Colorado, died suddenly on June 5, 1961. Harry Rasor was born in Elizabethton, Tennessee, on March 11, 1902, and graduated from the University of Missouri in 1926. He was licensed to practice in 1926 and served his internship at Sacramento City and County Hospital from 1926 to 1927. He then took his residency at Wieman Sanatorium, Wieman, California, from 1927 to 1928. He was elected to membership in the Lake County Medical Society on October 11, 1954, and became a member of the Colorado State Medical Society. Dr. Rasor was a conscientious worker and was liked by all in and around Dillon, Colorado. He is survived by his wife.

Abstract of Minutes*
House of Delegates of the
Colorado State Medical Society

SPECIAL SESSION
(With certain invited guests in attendance)
April 7-8, 1961
Empire Room, Denver Hilton Hotel, Denver

FIRST MEETING
Friday, April 7, 1961

Speaker Heman R. Bull, Grand Junction, called the House to order at 7:30 p.m. Speaker Bull and Vice Speaker Fredrick H. Good, Denver, alternated in presiding throughout the Special Session.

The Secretary read the official call for this Special Session, under date of March 27, 1961. The House listened to the invocation delivered by the Rev. Dr. Elmer C. Elsea, Pastor of the Central Presbyterian Church of Denver, after which the audience again rose and joined in the Pledge of Allegiance to the Flag.

The Speaker recognized Dr. Harper Kerr, of Pueblo, Chairman of the Committee on Constitution, By-Laws and Credentials, who reported that Dr. Douglas O. Kern would replace Dr. Richard D. Foe as delegate to the Special Session from Weld County, that Dr. R. G. Howlett had been appointed as an alternate delegate pro tem for Clear Creek Valley Medical Society, and that in the inability of delegate Albert Tipple and Alternate John Anderson, from Pueblo County Medical Society to attend this session, Dr. Carl W. Swartz, of Pueblo, was appointed as substitute alternate for this session only.

Speaker Bull noted that with positive registration at the door, a roll call at this first meeting was unnecessary. The Secretary noted that 87 accredited delegates (more than a quorum) were already present.

On motion, the report of the Credentials Committee was adopted.

Speaker Bull turned the chair over to President Cyrus W. Anderson, who proceeded to conduct the program with respect to Item No. 1 of the official call.

Ernest B. Howard, M.D., Chicago, Assistant Executive Vice President, American Medical Association, spoke on his subject, "The Issues, the Legislative Situation, and the Strategy."

Dr. Anderson presented Mr. R. B. Kennedy, Executive Secretary of the Mississippi State Medical Association, who introduced the Hon. John Bell Williams, Congressman from Mississippi, who addressed the meeting on the subject: "The Congressman's Problems Are Your Problems, Too."

Chairman Anderson then conducted a question and answer discussion period in which Dr. Howard and Mr. Williams participated. Dr. Anderson also introduced Mr. Leo E. Brown, Chicago, Mr. Frank K. Woolley, Chicago, and Dr. Bradford Murphey, Denver, who were scheduled to address the session on the following day. Dr. Anderson expressed gratification at the splendid attendance and turned the chair back to Speaker Bull, who requested that the two Special Session reference committees hold at least preliminary meetings immediately after adjournment of the evening meeting. Because of advance notice that several regular members of the Committee on Constitution, By-laws and Credentials could not be present, he appointed Drs. Harlan Huskey of Mesa County, Robert Humphrey of Larimer County, and James R. Leake of Arapahoe County as additional temporary members.

Speaker Bull appointed a Special Reference Committee on Legislation and Public Relations to consider all except Item No. 5 of the official call, to consist of Drs. V. L. Bolton, Chairman; William Lipscomb, Vice Chairman; R. G. Bosworth, John B. Farley, Samuel P. Newman, Victor Crumbaker, Robert L. McCurdy, and William S. Curtis.

The Credentials Committee approved the request from the San Luis Valley Medical Society

*Condensed from the shorthand and sound-recorded record of H. E. Dennis, Certified Shorthand Reporter. Reports referred to but not reproduced herein were distributed to all members of the House of Delegates at this Special Session, in mimeographed form. Copies of all such reports are on file with the Executive Office of the Society, and are available for study by any member of the Society.

to appoint Dr. Fred A. Rechnitz of Alamosa as delegate pro tem.

Vice Speaker Good again thanked the guest speakers and all who attended this evening. The House then adjourned until 8:30 a.m., April 8.

SECOND MEETING
Saturday, April 8, 1961

Speaker Bull called the House to order at 8:30 a.m. and the roll call disclosed 85 accredited members of the House present, more than a quorum. Dr. Reginald Fitz, alternate for Dr. Edward S. Miller, was seated on motion regularly made, seconded and carried without dissent.

Speaker Bull announced that Dr. Harlan McClure of Prowers County would act as Chairman of the Committee on Constitution, By-laws and Credentials in the temporary absence of Chairman Kerr. Speaker Bull then called on Dr. Cyrus Anderson, President, who read the report of the Board of Trustees to the House of Delegates. It had been prepared in advance and distributed to each member of the House.

The report was referred to the special Reference Committee on Legislation and Public Relations except for that paragraph in the report specifically marked for the Reference Committee on Constitution, By-laws and Credentials.

Speaker Bull called on Dr. Bradford Murphey to present the report of the Council on Governmental Relations, which had also been distributed in mimeographed form to all members of the House. Speaker Bull referred the report to the Special Reference Committee. He expressed special thanks to the two junior members of the staff who worked long hours last night to prepare the mimeographed material which was distributed to the House today. Both reference committees had held meetings last night.

The Reference Committee on Constitution, By-Laws and Credentials had prepared a preliminary report which had been mimeographed and distributed to members of the House.

Dr. McClure, acting Chairman of the Committee, stated that the proposed Standing Rule is to be re-referred to the Reference Committee on Constitution, By-Laws and Credentials and any suggestions for changes in wording should be expressed to the reference committee before the afternoon meeting of the House.

The House recessed briefly and reconvened at 9:45 a.m., together with invited guests, President Anderson presiding.

President Anderson introduced Leo E. Brown, Chicago, Director, Division of Communications, American Medical Association, who addressed the assembly on the subject, "What the American Medical Association Is Doing and Will Do."

Dr. Anderson then presented Frank K. Woolley, Chicago, Field Service Representative, American Medical Association, who spoke on the subject, "Here's What YOU Can Do"; and Bradford Murphey, M.D., Denver, Chairman, Council on Governmental Relations, Colorado State Medical Society, who spoke on the subject, "We and Our Allies Are Starting."

Dr. Anderson announced that there would be a practical workshop meeting in an adjoining room at 2:00 o'clock. He then turned the chair back to Speaker Bull, who adjourned the House until 2:00 p.m.

THIRD MEETING
2:00 p.m., Saturday, April 8, 1961

Speaker Bull called the meeting to order and noted the presence of a quorum, without roll call.

Report of the Reference Committee on Constitution, By-Laws and Credentials

Acting Chairman McClure: Your Reference Committee on Constitution, By-Laws and Credentials had reworded the proposed standing rules which were sent to it by the Board of Trustees, with further discussion during the noon hour.

Dr. McClure re-read the proposed rule as follows:

Rule No. 1: All resolutions or other proposals having as their purpose the establishment of Society policy or any change in existing Society policy, may be acted upon by the House of Delegates only if they have been referred to a reference committee. Copies of these resolutions should be in printed form for distribution to the delegates when feasible. These resolutions must then be considered at the next meeting of the House of Delegates.

Rule No. 2: Any resolution or other action of the House of Delegates which would require the expenditure of Society funds not already appropriated and not contemplated in the annual budget of the Society as presented by the Board of Trustees shall, after reference committee action, automatically be referred to the Board of Trustees for conclusive determination of its financial practicability, before presentation to the House of Delegates for final action at the next meeting of the House.

Vernon L. Bolton (El Paso, Chairman, Special Reference Committee): "I want to ask a question which came up with regard to this. In the statement it says: 'at the next meeting of the House.'

"Do you mean the next meeting of the House as Tuesday following Monday? Or fall following clinical session? Because if it were the latter, we wouldn't be able to put our proposals on the floor today."

Dr. McClure: "Tuesday following Monday, with the idea that there will be no new business on the last day of the House."

Dr. McClure moved the adoption of the report of the Reference Committee on Constitution, By-Laws and Credentials as read, the motion was seconded, there was no discussion, and it carried without dissent.

Report of the Special Session Reference Committee on Legislation and Public Relations

Chairman Bolton: "We could start this several ways, and one way I would like to start it is: 'Friends, Romans and Countrymen, we come to connote, not to denote.' We no longer are romanticists, but semanticists."

Your reference committee has reviewed the numbered paragraphs as carried in the official call dated March 27, 1961.

It recommends the approval of paragraphs 1 and 2 as published since they are of general intent.

Your reference committee considered Item No. 3 of the official call which reads:

"In view of national developments, to reconsider, and to consider re-enacting in different wording, the resolution adopted March 1, 1961, by the House relating to 'socialized medicine' ";

It is hereby recommended that the action taken under that heading be hereby rescinded and the following substituted, in its entirety as you have it in the report of this committee at this time:

"It is recognized that as a result of paragraphs 1 and 2 of the official call and the discussions held at this meeting we have a large problem, both nationally and locally, which requires concerted action once again of not just component societies but individual members to actively combat the continuing threat of socialized medicine.

"We recognize as always that the objective of the individual physician is still to render the best possible medical care to all patients regardless of age or segment of the population, and that this can best be done without the third party interference of governmental agencies.

"We further recognize that at this time this will take money, but we cannot help but reiterate that the money is the smallest part of this objective.

"However, in order to augment the individual efforts of all physicians, we suggest that the Board of Trustees exercise its authority as vested in the By-Laws to make a special assessment to assist in this program. In order that this not be alarming at the moment we suggest that for the beginning of this program this assessment not exceed $50.00 and shall apply to Active Members Senior as listed in the By-Laws. We further suggest though that the other classifications of members not above covered be requested to voluntarily contribute within their means, and that all parties be informed that they may voluntarily contribute above the assessment."

As an explanation at this point: We did this for the reason that it was suggested by several people that it could be a hardship on a beginning physician, or on a retired physician or an honorary physician, to contribute in the same manner as those of us who are engaged in active practice. Our By-Laws state that in the first three years of a man's practice he is not an Active Member Senior. This is limited to three years. I think that in itself will cover that particular concern we had.

"We as a committee felt that there is little doubt that the most pressing problem that faces not only organized medicine but the country as a whole is the now present attempt of those forces, within the Federal Government in particular, to further the intentions of socialization in general and socialized medicine in particular by approaching it through the care of the ill, but particularly the aged ill.

"We further suggest that the State Society again request component societies to organize their speakers' bureaus to disseminate such information as may become available to us through the A.M.A. and our state office, and that they actively pursue this program as seems practicable."

Dr. Bolton moved adoption of this section of the report. The motion was seconded.

Speaker Bull: "Is there any discussion? You are voting yourselves a $50.00 assessment. (No response.) It is acceptable, apparently, to everybody."

The motion carried without dissent.

Chairman Bolton: "The Board of Trustees has power to make assessments when they find it necessary, in practically any amount they find necessary. The reason we put it in a tentative figure for the beginning of this was so that no one would become alarmed that they are going to stick $1,000 on you today. They have the power and authority if they find it necessary to get, to take, to borrow, or to assess more money. This gives us a starting point. From this point we can determine where we need to go and how we can go. This is not in any way an attempt to limit the Trustees, but to give them some idea of our primary intention."

Dr. Bolton continued the reference committee report:

Your reference committee considered Item No. 4 of the official call with regard to the request of the Board of Trustees that we drop the investigation of charitable organizations. It was the unanimous opinion of this committee that we **not** drop this project. It is our opinion that this Society, as all societies, has been involved in many and serious problems almost on a continuing basis, and for that reason we cannot drop smaller items which arise in the middle of greater problems, lest they too become great.

It is recommended that the action taken by the House of Delegates at the Clinical Session 1961 with regard to organizations raising funds for private charities having to do with medical care, be rescinded in its entirety.

It is further recommended that the following be substituted:

"That the State Office through its existing facilities, using the simplest facilities such as the mail and telephone, solicit information from agencies, either national or local, who solicit funds in this state for charitable medical purposes. We would specifically request that these agencies send us a summary of the intent and objectives of their orgainzation and a copy of their annual fiscal reports.

"We further recommend that this be a continuing project and need not be done at one time, but that it be done in the most practicable manner.

"We further recommend that advantage be taken of the many sources of already existing information. In order to clarify a misunderstanding, it is not the intent of this recommendation that a separate and expensive investigative body be organized."

You have already taken action on paragraph 5 in the official call relating to standing rules. So we come back to the last part, paragraph 6. It will be necessary to go back to action taken at the conclusion of the March 1st meeting of the House. The committee did not feel that it wished, nor that there was any necessity, to rescind that action, but would like to reiterate it, and follow it with some further recommendations and suggestions.

Chairman Bolton then re-read, for emphasis, the recommendations of the Reference Committee on Legislation and Public Relations relating to the Old Age Pension Medical Care Program as adopted by the House of Delegates on March 1, 1961. (See pages 60, 61, May, 1961, issue of this Journal.) He then continued with the current report of the Special Session Reference Committee, and re-read in their entirety and reworded in one instance, the recommendations of the Council on Governmental Relations. The reference committee then moved their adoption by the House, as follows:

"1. The reference committee recommends that it be recognized that each hospital will form its own committee, in an admission and discharge utilization capacity, in accordance with its own problem and the size of its staff, and will select a title or name for the committee most representative of the function which the committee will perform in that hospital.

"2. The reference committee recommends that any hospital staff now using the revised form (MED-7) provided by Blue Cross for certification purposes and wishing to continue to use this form may do so. This recommendation is made in view of the clarification of intent outlined in the Blue Cross letter of March 31, to all participating hospitals. However, for those hospital staffs still objecting to the use of this form, the Council on Governmental Relations is working with the Welfare Department and Blue Cross on several suggested procedures (one of which appears below) to arrive at a solution that will be generally acceptable.

"Suggested Reporting Procedure for Admission and Discharge Committees: The medical staff of the hospital will request the hospital administrator to make a daily report to Blue Cross listing the names of OAP patients admitted that day, indicating that these patients were admitted on an 'emergency' basis and that the Admission and Discharge Committee, or some other committee with similar function, would examine the patients' records within the first eleven days of the hospital stay. It will be within the power of the committee to grant authorization for an extension should the patient's record indicate a need for additional hospitalization providing the attending physician has made a request to the committee for such extension. The hospital administrator

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1. Blank, P., and Boas, H.: Improved analgesia for moderate pain, Ann. West. Med. & Surg. 6:376, 1952. 2. Bonica, J. J., et al.: The management of postpartum pain with dihydrohydroxycodeinone (Percodan): Evaluation with codeine and placebo, West. J. Surg. 65:84, 1957. 3. Cass, L. J., and Frederick, W. S.: A controlled study in pain relief, M. Times 84:1318, 1956. 4. Chasko, W. J.: Pain-free dental surgery: Postoperative extension of the pain-free state, J. District of Columbia Dent. Soc. 31:3, No. 5, 1956. 5. Cozen, L.: Office Orthopedics, ed. 2, Philadelphia, Lea & Febiger, 1953, pp. 120, 138, 145, 156, 234. 6. Nicolson, W. P., Jr., and Skandalakis, J. E.: Control of postopera-tive pain, J.M.A. Georgia 46:471, 1957. 7. Piper, C. E., and Nicklas, F. W.: Percodan for pain in industrial practice, Indust. Med. 23:510, 1954; abstracted, Clin. Med. 3:1008, 1956, Current M. Digest 22:135, No. 3, 1955.

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would also be requested to make a daily report to Blue Cross listing the names of the OAP pensioners whose OAP Fund Benefits had been extended and that such extension had been authorized by the hospital's Admission and Discharge Committee or similar committee.

"3. The reference committee recommends that the House of Delegates reaffirm the authority vested by the By-Laws in the Council on Governmental Relations of this Society to make policy interpretations for the Society between meetings of the House regarding the Colorado Department of Public Welfare medical programs when such action is necessary.

"4. Since severe communications problems have arisen in regard to the OAP Medical Care Program, the reference committee recommends that a specific educational effort be made in regard to the program, providing such effort makes no dislocation in our Society's budget."

The reference committee report continued as follows:

We recognize that some of the things said here we have already said in March; but we are saying them again now through the terms and ideology of Brad Murphey whom we so devoutly believe. We have said these same things that are so important to us several times, not to be redundant but because we believe them that much. Having gone this far with the action of the House taken in March and reiterating our belief and recommendations as to what the Council on Governmental Relations has recommended, we have added this:

It is further recommended that steps be taken to eventually amend the law that has to do with the care of the old age pensioners in the state of Colorado, in such a manner that the full intent of the Kerr-Mills Law as approved by the A.M.A. may be implemented and put to use in this state.

We further recommend that actuarial information which is already available to our Blue Cross and Blue Shield organizations with regard to the care of the ill in general, and the aged in particular at this moment, be made available to the state's authorities. We feel this will help it to be recognized that a fixed sum is not practical or realistic for a population which is increasing in age, need, and number.

We further recommend that the State Welfare Department then consider making its budget on an actuarial basis in its future plans even though this may require a change in the law. We further suggest that it be recognized that the doctor's primary function in this program is to care for the ill and not to become a fiscal agent or representative of the state government. We recognize that much of the breakdown in communications here perhaps has arisen over the misunderstanding of the definition of the term "emergency." We are willing to accept for this stipulated time—which we understand is to be until July 1, 1961—this emergency condition which requires the use again of the term "emergency" for the use of patients, but we wish to make it known that we feel this term is in error; if it is to be continued it must be renegotiated and redefined at that time.

For this period of time as above stated we recognize the term "emergency" as more nearly being that of an urgent necessity.

Chairman Bolton then moved adoption of the final section of the reference committee report and adoption of the report as a whole, and expressed thanks to the many who had appeared at the committee's hearings. His motion was seconded and was carried without dissent.

At the request of the Speaker, Secretary Sethman first certified that all business named in the official call for this Special Session had been concluded, and then verified the roll call, pointing out that 91 out of a possible 99 voting seats in the House had been taken at this session.

Vice Speaker Good recognized Dr. John S. Bouslog, who moved that the House give a standing vote of thanks to the Board of Trustees, the guest speakers, the committees and staff and reference committees, and a special thanks to the Council on Governmental Relations, "all of whom have been doing such a tremendous job for us." There were many seconds, and all stood and applauded.

Vice Speaker Good announced that business was concluded and declared the House adjourned, without day, at 3:20 p.m.

The above abstract of minutes is respectfully submitted to the Society.

HARVEY T. SETHMAN,
Secretary, House of Delegates.

MONTANA

Proceedings of the House of Delegates Montana Medical Association 14th Interim Session

April 7-8, 1961
Helena

FIRST SESSION
April 7, 1961

The first meeting of the 14th Interim Session of the House of Delegates was called to order by the Vice President, Harold W. Fuller, M.D., at 8:40 a.m., April 7, at the Western Life Insurance Company Building, Helena.

The Secretary announced that all delegates seated had presented proper credentials and that a quorum was present.

It was moved and seconded that the reading of the minutes of the 82nd Annual Meeting held in Bozeman, September 15-17, 1960, be dispensed with. The minutes of the 82nd Annual Meeting were approved as published in the January, 1961, issue of the Rocky Mountain Medical Journal.

In the absence of Paul J. Gans, M.D., Delegate to the American Medical Association, the Secretary read his report upon the numerous actions of the House of Delegates of the American Medical Association at its 14th Clinical Meeting in Washington, D. C., November 28-December 1, 1960. This report of the Delegate was referred by Vice President Fuller to the Reference Committee on Officers, Meetings, and Administration for study.

William E. Harris, M.D., read the following report of the Secretary-Treasurer, which was referred by Vice President Fuller to the Reference Committee on Officers, Meetings, and Administration for study:

Secretary-Treasurer's report

After following the play by play, inner and outer political activities of the 37th Legislative Assembly of Montana, there seems to be very little that I may report to this 14th Interim Session of the House of Delegates.

Your Acting President, Harold W. Fuller, M.D., your Alternate Delegate, S. C. Pratt, M.D., and I

were a part of the delegation of the Montana Medical Association which attended the A.M.A. clinical session in Washington, D. C., last December. We were privileged to have a breakfast meeting with our distinguished Senator, Mike Mansfield. Our discussions with Senator Mansfield were rather general in nature but seemingly satisfying. I also conducted our neophyte Senator and his wife, Mr. and Mrs. Lee Metcalf, through the magnificent scientific exhibit section. They seemed duly impressed and were gracious guests.

Now, about facts at home. It is my belief that our medical fortunes were handled very adequately and intelligently during the recent legislative session. No legislation was presented which required the expenditure of costly legal fees or required any special assessments upon the membership in order to preserve the integrity of our medical life and practice.

It is again my pleasure and desire to thank our dependable and esteemed Executive Secretary, Russ Hegland, and his staff for their hard work and diligence.

As Treasurer of your Association, I would like to submit the following condensed report of income and expense for 1960:

INCOME:		
Membership dues	$35,998.50	
Interest on bonds and savings account	734.63	
Income from sale of exhibit space at annual meeting (net)	3,119.75	
Miscellaneous income (Rental received from Montana State Dental Association; sale of insurance forms and fee schedules; 1% rebate for collection of A.M.A. dues, etc.)	813.36	
Total Income		$40,675.24
EXPENSE:		
Office operations, including salaries, stationery, rent, postage, telephone, etc.	$22,147.27	
Expenses of officers, committees, delegates, alternate delegates, and Executive Secretary	5,037.73	
Expenses of annual and interim meetings	2,530.54	
Subscriptions to "Rocky Mountain Medical Journal" for members	1,352.50	
Membership in Public Health League of Montana for physicians	1,545.00	
Contributions to budget of Woman's Auxiliary to M.M.A.	1,918.00	
Legal and accounting fees	754.68	
Taxes paid	297.72	
Dues and contributions to other groups	405.00	
Miscellaneous expenses	683.40	
Total Expense		36,670.84
Excess of income over expense for 1960		$ 4,004.40

(Note: The Association was committed to liabilities of $11,000 during 1960 but none of them were paid during that year. A payment of $1,000 is due Mrs. Paul Phillips for editorial work on the history of medicine in Montana and $10,000 has been appropriated for publication of this volume but to date no charges have been assessed against this appropriation.)

During 1960, there were 538 active members (dues paying) of your Association. During previous years, the active membership was as follows:

1959—558	1956—523
1958—544	1955—503
1957—544	1954—472

As of March 8, however, only 340 members of this Association have remitted dues for membership during 1961. During the same period a year ago, the paid membership was 428. May I take this opportunity to urge that each member of this House of Delegates encourages all of the members of their component society to remit their dues promptly and also to encourage any physician who is not presently a member in good standing to file his application and become an active member in the local, state, and national medical societies.

Dr. Harris read a rather lengthy report in which was outlined the numerous actions of the Executive Committee on behalf of the Association since the annual meeting of the House of Delegates last September. This report of the Executive Committee was referred by Vice President Fuller to the Reference Committee on Officers, Meetings, and Administration for study.

The following supplemental report of the Executive Committee was then read by Secretary Harris: This report was referred by Vice President Fuller to the Reference Committee on Officers, Meetings, and Administration for study.

Executive Committee supplemental report

Your Executive Committee met on Thursday, April 6, to discuss and transact certain additional business of the Association. As a result of this meeting, it was voted that several proposals presented to the committee be referred to the appropriate standing committee of this Association for review, consideration, and recommendation.

The audit of the books of account of the Association for 1960 was carefully studied and reviewed by the committee. It was voted after discussion of the audit that it be accepted as prepared by the certified public accountants. A copy of the audit is available through the Secretary-Treasurer and may be inspected by any member of this House of Delegates upon request.

Members of the House will recall that at the annual meeting of the Association in Bozeman last September, it was voted that the interim session of this Association in 1962 and thereafter be limited to meetings of the House of Delegates and that these meetings of the Association be scheduled under a rotating plan in Kalispell, Miles City, Havre, Livingston, and Helena late in March or early in April. After a full discussion of this action of the House of Delegates, the Executive Committee voted that the 1962 interim session be held in Livingston, preferably on March 30 and 31. An invitation to convene the interim session in Livingston on these dates was extended to the committee by William E. Harris, M.D., on behalf of the Park-Sweetgrass Medical Society. If, by chance, these dates are not available for the meeting, the second choice of dates will be March 23 and 24.

The Executive Committee proposes to convene the House of Delegates for its first session for the introduction of committee reports, resolutions and new business on Friday, March 30, at 2:00 p.m., and to convene the second and final session of the House on Saturday, March 31, for the consideration of the reports of the several reference committees. It is also anticipated that on Friday evening, March 30, a reception and banquet, with perhaps an after dinner speaker, will be planned.

Paul J. Gans, M.D., President of Montana Physicians' Service, then presented a detailed report upon the activities of Montana Physicians' Service during the last six months and commented at length upon hospital utilization by beneficiary members of M.P.S. This report was then referred by Vice President Fuller to the Reference Committee on Affiliated Organizations for study.

Vice President Fuller then announced that the reports of the various standing and special committees and of the representatives of this Association to other groups, as well as the resolutions included in the file of each delegate, would be considered as business properly introduced to the House of Delegates for consideration and that these reports were hereby referred to the reference committee indicated in each report for study. Vice President Fuller then called for the introduction of additional resolutions and new business but none was presented for consideration.

Vice President Fuller then introduced Fredricka Alexander, M.D., a medical missionary who was visiting in Helena and was present at this meeting of the House of Delegates. He also read a letter of greetings and best wishes to the membership of this Association from Raymond F. Peterson, M.D., President, who is now engaged in the practice of his specialty in California.

The first session of the House of Delegates recessed at 9:15 a.m.

SECOND SESSION
April 8, 1961

The second session of the 14th Interim Session of the House of Delegates of the Montana Medical Association was called to order by Harold W. Fuller, M.D., Vice President, at 8:40 a.m. in the Western Life Insurance Company Building, Helena.

Following the roll call, William E. Harris, M.D., Secretary, announced that a quorum was present.

Upon motion, regularly seconded and carried, the following members of this Association were seated as delegates to represent the component society indicated:

William B. Danner, M.D., Southeastern Montana Medical Society.

T. L. Hawkins, M.D., Lewis and Clark Medical Society.

Vice President Fuller called for the introduction of additional resolutions and new business but none was presented.

T. L. Hawkins, M.D., Secretary-Treasurer of the State Board of Medical Examiners, then reported upon the amendments to the Medical Practice Act which had been adopted by the legislative assembly during February and discussed several of the more important activities of the Board of Medical Examiners during the past few months. Dr. Hawkins, in his report, indicated that the Board of Medical Examiners will hereafter become more aggressive in the prosecution of violators of the Medical Practice Act and requested that members of the House of Delegates inform him as promptly as possible of violations of the act. He indicated in his report that the Board of Medical Examiners will hold a special meeting on the first Tuesday of October, 1961, to examine candidates for licensure in Montana and that thereafter, as provided by the amendments to the Medical Practice Act, the Board of Medical Examiners will meet on the second Tuesday of January and July of each year to examine such candidates for licensure.

Reference Committee reports

The following report was presented by William B. Danner, M.D., Chairman of the Reference Committee on Officers, Meetings, and Administration:

Your Reference Committee on Officers, Meetings, and Administration studied and considered carefully the several reports referred to it. It submits the following comments and recommendations upon these reports:

Report of the Delegate to the A.M.A.: Your reference committee reviewed with interest the report of the Delegate to the American Medical Association, Paul J. Gans, M.D. It commends him for the excellence of his comments. In his report, Dr. Gans requested an expression of opinion of the members of this Association upon the proposal of the American Medical Association to increase its annual dues for membership. Your reference committee is of the opinion that the justifications for the increase were duplications of services in some instances and that an increase in A.M.A. dues on this basis was not necessarily warranted at this time.

It was moved by Dr. Danner and seconded that this portion of the report of the reference committee be adopted. During the discussion of this motion it was pointed out that a large portion of the additional income of the A.M.A. from the proposed increase in membership dues will be devoted to establishing a student loan and scholarship program. Several members of the House of Delegates strongly supported this program which, it is anticipated, will eventually increase the number of well qualified students in medical schools. These members of the House of Delegates expressed the opinion that if such a student loan fund and scholarship program were not initiated and sponsored by the American Medical Association, it was likely that a similar program would be sponsored by the federal government and that the sponsorship of such a program by the government should be avoided at all costs. During this discussion, it was also pointed out that the American Medical Association has properly and adequately represented the medical profession in every possible manner and it, therefore, deserves the full and unqualified support of all physicians. Dr. Gans reported that in addition the medical profession faces a critical period in combating the enactment of certain federal legislative proposals and that this campaign will require heavier financial support. It was then suggested that members of the House of Delegates of this Association support as strongly as possible the proposal to increase the dues for membership in the American Medical Association by defeating the motion to adopt this portion of the report of the reference committee. After a call for the question, the motion by Dr. Danner was voted upon but failed to carry.

Report of the Executive Committee: Your reference committee studied with considerable interest the report of the Executive Committee of this Association. Inasmuch as the report of the Executive Committee is basically informative, your reference committee is of the opinion that no action upon it is necessary.

This portion of the report was adopted.

Following its study of the supplemental report of the Executive Committee in which the plan and schedule for future interim sessions of this House of Delegates were discussed, your reference committee suggests that the proposals of the Executive Committee for future interim sessions be approved but that a brief scientific session be included as a portion of the program so that the expenses of delegates for travel to the interim sessions of the House of Delegates may be deductible for income tax purposes.

This portion of the report was adopted.

Report of the Secretary-Treasurer: Your reference committee studied with interest the report of the Secretary-Treasurer and suggests that it be reviewed carefully by all members of this House of Delegates. Inasmuch as the report of the Secretary-Treasurer is largely informative, your reference committee is of the opinion that no action upon it is necessary.

This portion of the report was adopted, as was the report of the Reference Committee on Officers, Meetings, and Administration, as amended, as a whole.

For the information of the members of the House of Delegates, William E. Harris, M.D., Secretary-Treasurer, read a telegram from Mr. David Werner, Chairman of the Livingston Chamber of Commerce, extending an invitation to this House of Delegates to convene its 1962 interim session in Livingston.

The following report was presented by James R. Thompson, M.D., Chairman of the Reference Committee on Legislation and Public Relations:

Your reference committee carefully reviewed and considered the reports of the Public Relations Committee and of the Legislative Committee.

Report of the Public Relations Committee: Your reference committee was happy to note in the report of the Public Relations Committee that although it had not convened during the last six months, it had nevertheless been active in several affairs concerning the public relations of the Association and the medical profession. Public relations is certainly one of the most necessary and important areas of activity of the Montana Medical Association and its Public Relations Committee should receive the full cooperation of all members continually. Your reference committee looks forward to the review of the accomplishments of this most important committee during the next six months. Since the report of the Public Relations Committee which is presented to the House of Delegates for consideration is primarily informative, your reference committee is of the opinion that no action upon it is necessary at this time.

This portion of the report was adopted.

Report of the Legislative Committee: Your reference committee reviewed the excellent and gratifying report presented by the Chairman of the Legislative Committee, Amos R. Little, Jr., M.D. It is the opinion of this reference committee that each member of this Association should read carefully the entire report of the Legislative Committee and consider it deliberately and seriously. The basic issues of legislation and government are well presented and the conclusions realistic and mature. Your reference committee wishes to advise the House of Delegates that the information requested by the Chairman of the Committee on Emergency Medical Service about the introduction of civil defense legislation is properly and appropriately furnished in the last paragraph of the report of the Committee on Legislation. Inasmuch as the report of this committee is informative and contains no specific recommendations, it is the opinion of your reference committee that no action upon it is necessary.

This portion of the report was adopted, as was the report of the Reference Committee on Legislation and Public Relations as a whole.

The following report was presented by F. Hughes Crago, M.D., on behalf of Henry D. Rossiter, M.D., Chairman of the Reference Committee on Legal Affairs and Professional Relations:

Your Reference Committee on Legal Affairs and Professional Relations reviewed the reports of the following committees of this Association:

Legal Affairs Committee: The Legal Affairs Committee reports that several instances of legal action against members of this Association have been settled out of court in a manner agreeable to all those concerned. The committee adds that three possible legal actions have also been agreeably settled by the grievance or mediation committees of component medical societies, but that one case is now pending before the committee and is under active consideration. Your reference committee joins the Legal Affairs Committee in commending the active mediation and grievance committees of the several component societies of this Association and upon their successful operations. Inasmuch as the report of this committee is primarily informative, your reference committee is of the opinion that no action upon it is necessary.

This portion of the report was adopted.

Report of the Economic Committee: The Chairman of the Economic Committee in his report indicates that no meeting of his committee has been held since September but that it will meet on April 8 with representatives of the Veterans Administration at Fort Harrison and that negotiations are under way for the adoption of a new schedule of fees for medical and surgical services to veterans for service connected disabilities. Your reference committee is happy to learn of these negotiations and will anticipate a further report upon them during the annual meeting of the House of Delegates. Since the report of the Economic Committee was primarily informative, your reference committee is of the opinion that no action upon it is necessary.

This portion of the report was adopted.

Hospital Relations Committee: Your reference committee reviewed with great interest the report of the Hospital Relations Committee and its comments upon the first hospital relations conference which was held in Great Falls during November, 1960. The report of this committee indicates that the total registration at this conference was disappointing but that the interest and enthusiasm of those who registered was great. It appears from the report that the sponsorship of this conference was the first and a most important step in the improvement of relationships between physicians and those interested in and concerned with hospital administration and management. In the opinion of your reference committee, it is anticipated that with greater participation in future conferences the objectives of this committee will be achieved. Members of the Hospital Relations Committee are to be commended for completing a splendid step in a most important aspect of physician-hospital relationships. Your reference committee recommends that members of this House of Delegates urge that every member of their component medical society make every effort to attend the second conference to be planned and sponsored by the Hospital Relations Committee during the fall of this year.

This portion of the report was adopted.

Committee on Necrology and History of Medicine: The Committee on Necrology and History of Medicine reports the death of the following Montana physicians since the last meeting of this House of Delegates:

Roland G. Keeton, M.D., Bozeman, September 21, 1960.
Halward M. Biegen, M.D., Missoula, April 2, 1961.

Montana physicians extend to the family and friends of each of these physicians their sincere sympathy and condolences. It is appropriate at this time that the respects of each member of the medical profession be recorded in the minutes of this meeting of the House of Delegates in recognition of these physicians who have served the people of Montana and their profession with such distinction.

(The members of the House of Delegates rose and paused in silence in memory of these physicians.)

The Committee on Necrology and History of Medicine is to be commended upon its selection of the late Ferdinand Ripley Schemm, M.D., Great Falls, as a distinguished Montana physician about whom a feature story will be published in a forthcoming issue of "Postgraduate Medicine."

Your reference committee is indeed happy to learn that final arrangements for publication of the book, "Medicine in the Making of Montana," will soon be completed and that this interesting and entertaining monograph will soon be available for publication.

This portion of the report was adopted.

Advisory Committee to the Industrial Accident Board: The report of the Advisory Committee to the Industrial Accident Board includes gratifying information for all Montana physicians. At long last an equitable schedule of fees has been negotiated with the Industrial Accident Board. The negotiation of this new schedule has been accomplished through long and untiring efforts of the members of the advisory committee and especially of its Chairman, James J. McCabe, M.D. Your reference committee, on behalf of all Montana physicians, expresses its appreciation to Dr. McCabe and to the other members of his committee for their accomplishments. Inasmuch as the report of this committee is basically informative, your reference committee is of the opinion that no action upon it is necessary.

This portion of the report was adopted, as was the report of the Reference Committee on Legal Affairs and Professional Relations as a whole.

Leonard W. Brewer, M.D., for the information of the members of the House of Delegates, reported that negotiations for the publication of the volume, "Medicine in the Making of Montana," will probably be completed during the next few weeks. This volume, it is anticipated, will be printed by the University Press, Missoula, and promoted and sold by the Montana Historical Society, Helena.

The following report was presented by C. H. Swanson, Jr., M.D., Chairman of the Reference Committee on Resolutions and New Business:

Resolutions and New Business

Your Reference Committee on Resolutions and New Business met on April 7 to review and consider the several resolutions submitted to it for study. The following resolution upon the continuation of liaison with appropriate committees of the Montana Osteopathic Association was submitted for consideration by the Southeastern Montana Medical Society:

WHEREAS, At the January 8, 1961, special meeting of the House of Delegates of the Montana Medical Association, 41 per cent of the Delegates present favored the action of the Executive Committee regarding its proposal to license osteopaths; and

WHEREAS, This percentage represented the wishes of eight of a total of 14 component medical societies; now, therefore, be it

RESOLVED, That the House of Delegates of the Montana Medical Association instruct its Liaison Committee to continue relationships with the Liaison Committee of the Montana Osteopathic Association; and be it

RESOLVED further, That a model bill be prepared and presented for formal action by the House of Delegates of the Montana Medical Association at its 1962 annual meeting.

Your reference committee discussed this resolution with members of the present Liaison Committee to the Montana Osteopathic Association and with representatives of the Southeastern Montana Medical Society. Members of this society expressed the opinion that failure to reach a mutually acceptable understanding with members of the osteopathic profession may be detrimental to the position of this Association with members of the state legislature. In addition, they reported upon the progress of negotiations between physicians and osteopaths in California which seem to indicate that the osteopathic school in that state will soon become a school of medicine under its state university system. Your reference committee is of the opinion that this resolution should be adopted and liaison with the Montana Osteopathic Association continued, provided the members of the Liaison Committee are not compelled under this resolution to introduce a model medical practice act during the legislative assembly in 1963 which will include the practice of medicine and surgery by osteopaths. Your reference committee, therefore, recommends that the resolution be amended by deleting the following section of the resolution and that as amended, the resolution be adopted:

"and be it RESOLVED further, That a model bill be prepared and presented for formal action by the House of

Delegates of the Montana Medical Association at its 1962 annual meeting."

It was moved by Dr. Swanson and seconded that this portion of the report of the reference committee be adopted. During the discussion of this motion, it was suggested that a solution to this problem by legislation was improper and not upholding trust which patients placed with their physicians. It was suggested, in addition, that it was appropriate to continue liaison relationships with the osteopathic profession in Montana but that such a continuation of relationships should not imply any commitment of this House of Delegates or approval of previous proposals. Reports and recommendations of such continued liaison, it was pointed out, must be submitted at a future date for the consideration and approval of this House of Delegates. Following further discussion, it was regularly moved and seconded that this portion of the report of the Reference Committee on Resolutions and New Business be tabled since such action would permit continued liaison without commitment of any opinions by this House of Delegates. The motion to table this portion of this resolution was then voted upon and carried.

Your reference committee carefully studied the resolution upon general practice residencies which was submitted to this House of Delegates for action by T. D. Callan, M.D., Anaconda, on behalf of the Montana Academy of General Practice. Members of your reference committee were uninformed upon the adequacy of general practice residencies and did not feel, therefore, that the resolution should contain reference to these residencies. The reference committee proposes to amend this resolution so that it will read as follows:

WHEREAS, Many general practice residencies are unfilled; and

WHEREAS, Each segment of organized medicine has—and still—determines the minute details and over-all content of their respective training programs; therefore, be it

RESOLVED, That the House of Delegates of the Montana Medical Association recommend that the House of Delegates of the American Medical Association urge that the Council on Medical Education and Hospitals formulate other two-year pilot progressive training programs which are acceptable to the American Academy of General Practice, the only national association representing general practice; and be it

RESOLVED further, That a copy of this resolution be forwarded to the Executive Vice President of the American Medical Association and to the Secretary of the American Academy of General Practice.

It was moved by Dr. Swanson and seconded that this portion of the report of the reference committee be adopted. During the discussion of this resolution, it was suggested by several members of the House of Delegates that since they were not fully informed upon the advisability of the adoption of such a resolution, it should not be adopted by this House of Delegates. It was then regularly moved and seconded that this portion of the report of the reference committee be tabled. This motion, after a vote, was carried.

Your reference committee heartily concurs with the following resolution which was introduced by John A. Layne, M.D., the liaison representative of this Association to the Council on Legislative Activities of the American Medical Association:

WHEREAS, The Congress of the United States has for several sessions considered various bills relative to provisions and subsidization of the cost of illness of older people; and

WHEREAS, The physicians of the State of Montana consider such bills to be socialized medicine for a special group of our population; and

WHEREAS, The estimated cost of any of these plans is admittedly unpredictable but certainly high; and

WHEREAS, The majority of individuals over the age of 65 do not require federal assistance; and

WHEREAS, In Montana, physicians have always contributed their services to the care of the indigent and semi-indigent of all ages; and

WHEREAS, Studies at county levels in Montana have failed to demonstrate any degree of unmet needs which would warrant federal interference in providing care for any age group; and

WHEREAS, It is the desire of the members of the Montana Medical Association to improve the medical care of all persons; and

WHEREAS, The members of the Montana Medical Association believe that political medical practice will hinder and not improve this medical care; now, therefore, be it

RESOLVED, That the House of Delegates of the Montana Medical Association, meeting in its interim session in the City of Helena, Montana, this, the eighth day of April, 1961, commend those members of the Congress and all others who have maintained steadfast opposition to furthering the cause of socialism; and be it

RESOLVED further, That the American Medical Association's positive eight-point program for the care of the aging be endorsed, publicized, and efforts at implementation expanded in this state by the Montana Medical Association and that it wholeheartedly endorses medical care to needy older persons under the Kerr-Mills Law; and be it

RESOLVED further, That a copy of this resolution be sent to the President of the United States, the Vice President of the United States, the Speaker of the House of Representatives, the members of the House Ways and Means Committee, the Secretary of Health, Education, and Welfare, the Governor of the State of Montana, the honorable members of the Montana congressional delegation, and the members of the Board of Trustees of the American Medical Association.

Your reference committee recommends the adoption of this resolution by this House of Delegates.

This portion of the report was unanimously adopted.

Your Reference Committee on Resolutions and New Business recommends that this House of Delegates instruct the Secretary of this Association to address appropriate letters of appreciation to each of the guest speakers who participated in the scientific portions of this interim session, to the management of the Western Life Insurance Company Building, to the Placer Hotel, to Jorgenson's Holiday Inn, to the officers and members of the Local Arrangement Committee and the Lewis and Clark Medical Society, to the Program Committee of this Association, and to all other individuals and organizations which contributed to the success of the 14th Interim Session of this Association.

This portion of the report was adopted unanimously and the report of the Reference Committee on Resolutions and New Business was adopted as amended, as a whole.

Vice President Fuller then introduced William F. Cashmore, M.D., Helena, who served as a member of the Senate from Lewis and Clark County during the 1961 session of the legislature and expressed to Dr. Cashmore, to Robert T. O'Neill, M.D., Roundup, who also served as a member of the State Senate, and to Samuel A. Weeks, M.D., Baker, who served as a member of the Montana House of Representatives during the legislative session, the sincere appreciation of the medical profession and of the members of this Association for their services to the State of Montana and to the health and welfare of its citizens. Dr. Cashmore then addressed the House of Delegates and discussed a number of the bills which had been enacted into law by the legislative assembly which were of particular interest to the medical profession.

The following report was presented by F. S. Marks, M.D., on behalf of Frank M. Campbell,

M.D., Chairman of the Reference Committee on Affiliated Organizations:

Your Reference Committee on Affiliated Organizations reviewed with interest two reports which were referred to it for study and recommendation to this House of Delegates.

Report of the Chairman for Montana of the American Medical Education Foundation: Your reference committee was surprised to learn that the number of contributions to medical schools and the amount contributed by these Montana physicians was as low as indicated in the report of the Chairman. Approximately 20 per cent of the physicians in Montana during 1960 contributed $2,883 to the American Medical Education Foundation. Your reference committee, therefore, considered carefully the mandatory assessment of $20 per year per member which was recommended for approval in the report of the Chairman for Montana. It is the recommendation of your Reference Committee on Affiliated Organizations that

a) contributions remain on a voluntary basis at the present time;

b) that an accelerated and more effective campaign be instituted to encourage all members of this Association to support adequately the American Medical Education Foundation;

c) that state-wide percentages of the contributions of physicians be recorded by membership in component medical societies and that these percentages and contributions by the membership of each of the component societies be published periodically in the "Bulletin";

d) that the annual voluntary contribution to the American Medical Education Foundation in Montana average not less than $25 per member;

e) that all physicians in Montana forward their annual voluntary contribution to their medical school to the office of the American Medical Education Foundation, designating, if they desire, the medical school to which the contribution shall be allocated.

Dr. Marks moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried after a discussion of the need for greater participation in the campaign of the American Medical Education Foundation for the support of medical schools.

Your reference committee reviewed the report of the representative of this Association to the Advisory Committee for Practical Nursing, Deane C. Epler, M.D., and wishes to express to him its appreciation for his active participation as a member of this advisory committee. Since his report to this House of Delegates is informative, your reference committee is of the opinion that no action upon it is necessary.

This portion of the report was adopted, as was the report of the Reference Committee on Affiliated Organizations be adopted as a whole.

The following report was presented by H. A. Braun, M.D., Chairman of the Reference Committee on Health and Well-Being:

Report of the Committee on Indian Health: The Committee on Indian Health of your Association recommends that this House of Delegates address a letter to the Advisory Committee on Indian Health of the Surgeon General of the United States Public Health Service to welcome to Montana this advisory committee which plans to meet in Glacier Park during August, 1961, and that the Association offer its assistance to the advisory committee.

This portion of the report was adopted.

Report of the Emergency Medical Service Committee: Your reference committee reviewed with interest the report of the Emergency Medical Service Committee. This report contains no recommendations and your reference committee is of the opinion that no action upon it is necessary. This committee, however, submitted the following supplemental report to this reference committee:

"Each member of the Emergency Medical Service Committee reviewed the material submitted from the Medic-Alert Foundation which requested approval of it and assistance to publicize the availability of its emblem which is intended to protect persons with medical problems and to aid personnel or agencies rendering emergency medical care to such individuals. It was the opinion of the members of this committee that the Montana Medical Association may endorse this nonprofit organization, its objectives, and emblem.

"The Medic-Alert Foundation was established in 1956. Its objectives are to establish throughout the world a universally recognized emblem to indicate that the wearer of it has a medical problem which must be recognized in an emergency. On the back of the emblem is engraved the medical problem of the wearer and, therefore, denotes that the person has such a problem but does not conspicuously designate him as a particularly diseased individual. Many individuals who wear the emblem merely have their name, address, and blood type engraved upon it. In addition is engraved a serial number. This serial number is retained in the files of the Medic-Alert Foundation along with additional information so that it will become readily available in any emergency. At the present time, there are between 40,000 and 45,000 persons who utilize the emblem of this foundation. The members of your Committee on Emergency Medical Service recommend that the Medic-Alert Foundation be given full approval and endorsement by this Association and further that the Association publicize the availability of the emblem and the services of the foundation to professional people as well as to lay persons in the State of Montana."

Your reference committee concurs with the recommendations contained in this report and suggests their approval by this House of Delegates.

This portion of the report was adopted, as was the report of the Reference Committee on Health and Well-Being as a whole.

In the absence of the Chairman of the Reference Committee on Scientific Work, the following report was presented by William E. Harris, M.D., Secretary-Treasurer:

Your Reference Committee on Scientific Work reviewed and considered the three reports which were referred to it for study.

Report of Subcommittee on Obstetrics: The report of the Subcommittee on Obstetrics of the Maternal and Child Welfare Committee submitted no recommendations for the consideration of this House of Delegates. The report, however, indicated that the Subcommittee on Obstetrics has continued its study of perinatal and maternal death records and that as a result of this study, periodical announcements are inserted in the "Bulletin" upon the recommendations of the Maternal and Child Welfare Committee for the improvement of the care of obstetrical patients. Inasmuch as this report is primarily informative, your reference committee is of the opinion that no action upon it is necessary.

This portion of the report was adopted.

Report of the Cancer Committee: Your reference committee reviewed the activities of the Cancer Committee with interest. It approved the recommendations of the Profession Service Committee of the Montana Division of the American Cancer Society which limits payment of palliative drugs for indigent patients to a specific amount, giving the attending physician a free choice of palliative medication. The Cancer Committee in its report indicates that it has agreed to act in an advisory capacity to the Cancer Control Program in public education sponsored by the State Board of Health. The report of the Cancer Committee is primarily informative and your reference committee is, therefore, of the opinion that no action upon it is necessary.

This portion of the report was adopted.

Report of the Committee on Mental Hygiene: Your reference committee, after reviewing the very informative report of the Committee on Mental Hygiene, recommends endorsement of the statement by the American Psychiatric Association upon hypnosis which was included as a part of the report. Although the Committee on Mental Hygiene implies in its report a desire that this statement be accepted as policy by this Association, it does not specifically submit this recommendation. Your reference committee, however, does concur with the statement of policy by the American Psychiatric Association and it approves of the following recommendations which are included as a portion of this statement:

1) Isolated courses limited to the teaching of trace induction technics are strongly disapproved.

2) The teaching of hypnosis should take place in medical schools and other psychiatric training centers that have an interest in the teaching of hypnosis. When taught in such a climate, where students can acquire adequate knowledge of psychiatric principles, hypnosis may become a useful adjunct to therapy.

3) The teaching of hypnosis should be of sufficient duration and depth for students to acquire adequate understanding of its appropriate place in relation to other psychiatric treatment modalities; of its indications and contraindications; of

its values and its dangers. Decisions regarding the depth and extent of the teaching of hypnosis should remain flexible, and should be made by the psychiatric departments teaching such courses.

4) Training in all aspects of hypnosis should be made available to physicians and dentists requesting it.

5) An expansion of facilities for the teaching of hypnosis is needed particularly at the postgraduate level. The establishment of postgraduate courses in medical schools and other teaching centers under the direction of the department of psychiatry is recommended.

6) Physicians practicing hypnosis should do so only in their particular field of medical competence.

7) The need for continued study of hypnosis and for adequate research is emphasized, with particular reference to delineating its place in the total treatment program.

Your reference committee suggests the approval of these recommendations by this House of Delegates and of the report of the committee.

This portion of the report and the report of the Reference Committee on Scientific Work, as a whole, were adopted.

Vice President Fuller then introduced John A. Layne, M.D., Great Falls, who was recently appointed to the Board of Trustees of the American Medical Association to serve as the liaison representative in Montana to the Council on Legislative Activities. Dr. Layne then reported briefly upon a meeting of the representatives of all state medical associations in Chicago for the consideration and discussion of national legislative problems. In his discussion, Dr. Layne emphasized the necessity of participation in political affairs by physicians and indicated that the present lethargy and willingness of certain groups to compromise must be overcome. He suggested that if the medical profession is to be successful in its campaign to combat present tendencies to socialize the medical profession and health care, it must develop an appropriate organization to accomplish this purpose. Dr. Layne then moved that this House of Delegates recommend that each component medical society of the Montana Medical Association appoint a committee or legislative liaison representative to work directly with the state liaison representative of the A.M.A. Council on Legislative Activities, the office of the American Medical Association, and the office of the Executive Secretary of the Montana Medical Association on all aspects of national legislative problems. This motion was seconded and following a brief discussion carried.

S. C. Pratt, M.D., Miles City, Alternate Delegate to the American Medical Association, moved that this House of Delegates endorse the activities of the two members of the Woman's Auxiliary to this Association in the work of the Woman's Auxiliary to the American Medical Association and that it express its deep appreciation and thanks for their active participation and interest in the national organization to Mrs. M. A. Gold, Butte, and Mrs. James D. Morrison, Billings, and that a copy of this resolution be forwarded to the appropriate officers of the Woman's Auxiliary to the American Medical Association so that they will be informed of the interest and the support of this House of Delegates in the activities of Mrs. Gold and Mrs. Morrison. This motion was seconded and unanimously carried.

There being no further business, the House of Delegates adjourned, sine die, at 11:50 a.m.

The following delegates, alternate delegates, and members were present at the interim session of the House of Delegates:

CASCADE COUNTY MEDICAL SOCIETY: Robert M. Addison, M.D., Great Falls; H. V. Anderson, M.D., Great Falls; F. Hughes Crago, M.D., Great Falls; H. V. Gibson, M.D., Great Falls; John R. Halseth, M.D., Great Falls; John A. Layne, M.D., Great Falls; William R. Lee, M.D., Great Falls; William E. Sullens, M.D., Great Falls.

FERGUS COUNTY MEDICAL SOCIETY: John W. Schubert, M.D., Lewistown; Paul J. Gans, M.D., Lewistown.

FLATHEAD COUNTY MEDICAL SOCIETY: R. A. Benke, M.D., Kalispell; C. E. Trush, M.D., Kalispell.

GALLATIN COUNTY MEDICAL SOCIETY: Edward E. Bertagnolli, M.D., Three Forks; Alan Iddles, M.D., Bozeman; Edward J. Purdey, M.D., Bozeman.

HILL COUNTY MEDICAL SOCIETY: Richard S. Buker, Jr., M.D., Chester; Chester W. Lawson, M.D., Havre; John Margaris, M.D., Big Sandy.

LEWIS AND CLARK MEDICAL SOCIETY: David T. Berg, M.D., Helena; J. R. Burgess, M.D., Helena; David P. Findley, M.D., Helena; William S. Harper, M.D., Helena; T. L. Hawkins, M.D., Helena; Raymond O. Lewis, M.D., Helena; Everett H. Lindstrom, M.D., Helena.

MOUNT POWELL MEDICAL SOCIETY: A. C. Knight, M.D., Galen; George E. Trobough, M.D., Anaconda; Mabel E. Tuchscherer, M.D., Anaconda.

NORTHCENTRAL MONTANA MEDICAL SOCIETY: George D. Waller, Cut Bank.

NORTHEASTERN MONTANA MEDICAL SOCIETY: Merle D. Fitz, M.D., Scobey; David Gregory, M.D., Glasgow.

PARK-SWEETGRASS MEDICAL SOCIETY: W. E. Harris, M.D., Livingston.

SILVER BOW COUNTY MEDICAL SOCIETY: L. I. Klatt, M.D., Whitehall; John A. Newman, M.D., Butte; R. W. Poundstone, M.D., Dillon.

SOUTHEASTERN MONTANA MEDICAL SOCIETY: William B. Danner, M.D., Sidney; B. C. Farrand, M.D., Jordan; Raymond W. Polk, M.D., Miles City; J. R. Thompson, M.D., Miles City.

WESTERN MONTANA MEDICAL SOCIETY: H. A. Braun, M.D., Missoula; Leonard W. Brewer, M.D., Missoula; B. D. Colwell, M.D., Missoula; John A. Evert, M.D., Missoula; A. R. Kintner, M.D., Missoula.

YELLOWSTONE VALLEY MEDICAL SOCIETY: W. A. Armstrong, M.D., Billings; Herbert T. Caraway, M.D., Billings; Paul R. Crellin, M.D., Billings; Walter H. Hagen, M.D., Billings; B. G. Hughett, M.D., Billings; F. S. Marks, M.D., Billings; C. H. Swanson, Jr., M.D., Columbus.

MEDICAL SCHOOL NOTES

Nation's medical students offered research fellowships by tobacco research group

To stimulate interest in research, students in the nation's 90 accredited medical colleges have been offered summer research fellowships for $500 by the Tobacco Industry Research Committee, it was announced recently.

"There is a serious shortage of basic research scientists," said Dr. Clarence Cook Little, scientific director of T.I.R.C. "The need for programs of this type has been stressed by many groups, including the recent President's Conference on

Heart Disease and Cancer.

"This program, now in its seventh year, is designed to encourage students to make a career in research. For those who enter other fields of medicine, it will provide valuable exposure to research."

Dr. Little said the student fellows, who are selected by their medical school deans, may do research in any field they choose. One student from each of the nation's accredited medical schools may receive a fellowship.

Canon City student honored

Winner of an A.M.A. honorable mention citation for his exhibit in the basic medical sciences at the 12th National Science Fair-International in Kansas City, Mo., May 10-13, was Gary J. Hartman, 17, Denver, a junior at Abbey School in Canon City, Colo. Hosts at the Health Awards Banquet, attended by 1,100 students and their sponsors, were the American Medical Association, the American Dental Association, the American Pharmaceutical Association, and the American Veterinary Medical Association. All four Presidents were on hand, and Dr. E. Vincent Askey, Los Angeles, presented the citation. Two years ago the Abbey School also gave the A.M.A. a first-place winner, Martin J. Murphy, Jr., of Colorado Springs, who is now a premedical student at Marquette University. Dr. Samuel P. Newman, Denver, chairman of the A.M.A. Council on Scientific Assembly, headed the special judging committee at the fair. Gary's exhibit was entitled, "Regeneration of Bone Marrow Under Severe Stress."

Patterns of Disease

Funds for research in Parkinson's disease, this nation's second most prevalent neurologic disease, have increased almost ninefold in the past five years, according to the April issue of *Patterns of Disease*, a monthly Parke, Davis & Company publication for physicians.

Midsummer Radiological Conference

The Twenty-third Midsummer Radiological Conference of the Rocky Mountain Radiological Society will be held in Denver August 10, 11 and 12, 1961, at the Hilton Hotel, Convention Center—Level 2B.

Non-member registration fee—$10.00.

Thursday, August 10

Presiding: Peter E. Russo, M.D., Oklahoma City, Okla., President, Rocky Mountain Radiological Society, and John F. Bacon, M.D., First Vice President, Rocky Mountain Radiological Society, Ames, Iowa.

Guest speakers: William B. Seaman, M.D., New York, N. Y.; Walter T. Murphy, M.D., Buffalo, N. Y., and Harold G. Jacobson, M.D., New York, N. Y.

Friday, August 11

(Meetings this day are dedicated in honor of Eugene P. Pendergrass, M.D., Philadelphia, Pa., Pioneer Radiologist.)

Presiding: Walter Wasson, M.D., Denver, Colorado; Stuart A. Patterson, M.D., Fort Collins, Colorado; John H. Freed, Denver; Marcus J. Smith, M.D., Santa Fe, New Mexico, and David J. Stephenson, M.D., Denver.

Guest speakers (former residents of Dr. Pendergrass): Kenneth D. A. Allen, M.D., Denver; J. Gershon-Cohen, M.D., Philadelphia; John F. Weigen, M.D., Palo Alto, Calif.; Roderick L. Tondreau, M.D., Meadowbrook, Pa.; James C. Katterjohn, M..D, Hartford, Conn.; Gilbert W. Heublein, M.D., Hartford, Conn.; John M. Dennis, M.D., Baltimore, Md.; C. Richard Perryman, M.D., Pittsburgh; C. Harold Atkins, M.D., New York; Robert P. Barden, M.D., Philadelphia; Vern W. Ritter, M.D., Santa Rosa, Calif.; Ellwood W. Godfrey, M.D., Princeton, N. J.; Nathan P. Salner, M.D., Philadelphia, and J. Robert Andrews, M.D., Bethesda, Md.

Saturday, August 12

Presiding: Thomas J. Kennedy, M.D., President 1961-1962, Rocky Mountain Radiological Society, Denver.

Guest Speakers: Walter T. Murphy, M.D., Harold G. Jacobson, M.D., John F. Bacon, M.D., Sumner Holtz, M.D., St. Louis, Mo.; William B. Seaman, M.D., New York, and Charles E. Shopfner, M.D., Grand Junction, Colorado.

Fifteen scientific exhibits and 13 technical exhibits have been scheduled for this Conference.

Shadow or substance cont. from page 16

that the heart had enlarged and pleural fluid was present on the right side. However, the metastatic lesions were absent! Before moving to another state, a pyelogram (Fig. 3) showed distorted calyces of the remaining left kidney, indicative of a neoplasm. (The physician who had attended her at the time of the right nephrectomy stated that a deformed left kidney had also been present then.) Three years after the time of Fig. 1, the patient died in uremia, and an autopsy revealed multiple hypernephromas of the left kidney with metastases to the lungs.

Epicrisis

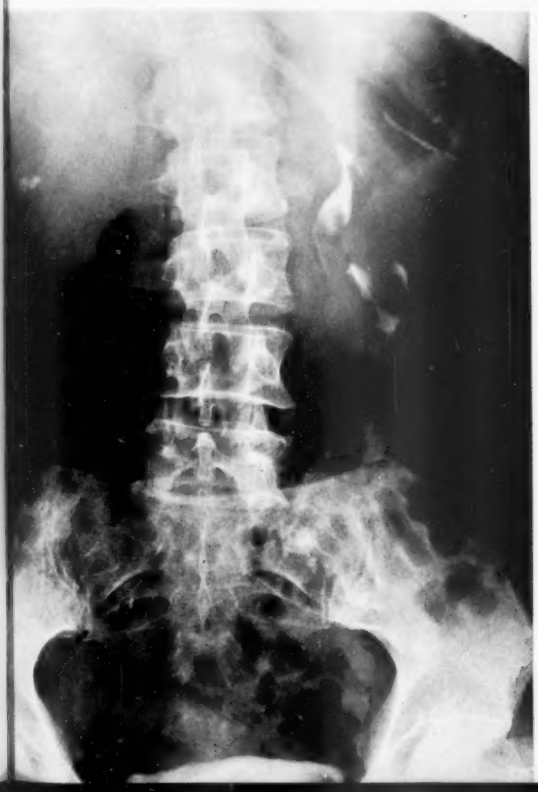
What was the nature of the pulmonary nodules seen in Fig. 1? At that time, we had seen no reason to urge histological corroboration of these suspected metastases. Later, after eliminating other possibilities, we were left with a clinical situation and terminal findings which suggested that we had witnessed a transient disappearance of metastases, without specific treatment. This is not impossible. That cancer can spontaneously regress is attested to by 600 published reports[2], of which 47 have sufficient documentation to verify this conjecture.

REFERENCES

[1]Greene, L. F., and Rosenthal, M. H.: Multiple Hypernephromas of the Kidney in Association With Lindau's Disease. New England J. Med. 244:633, 1951.

[2]Everson, T. C., and Cole, W. H.: Spontaneous Regression of Cancer: Preliminary Report. Ann. Surg. 144:366, 1956.

Fig. 3



Mass media cont. from page 26

audiences, and when appropriate to respond to direct requests which perform a public service (with recourse to appropriate authorities of his county society encouraged when advice, counsel, and/or clearance would be reasonably indicated).

Fear of indictment by one's colleagues as a "publicity seeker" has been a major obstacle to comfortable communication between the physician and his lay-public, and doubtless has contributed much to the "secret society" label imputed to organized medicine and its specialty groups. That indictments of such "publicity" are largely groundless is testified by Dr. James R. Fox, who as a veteran of the Minnesota Medical Association's radio and television productions estimates that he has received over $220,000 worth of personal publicity through eight years of broadcasting, but that during that time only six listeners ever called for appointments as a direct result of hearing his programs. "Most people," he concludes, "project their own family physician into the role of the TV doctor."

Press representatives at recent "Code of Cooperation" conferences have cited repeated incidents damaging to communication and public understanding—incidents which could have been averted (a) if the physician or hospital authority had been readily available for factual confirmation, (b) if the physician had been willing to provide a minimal and ethical statement of nonprivileged facts, and (c) if the physician had not been unnecessarily fearful of criticism by colleagues (or at least had not been unaware of his rights and obligations to inform responsible mass media representatives, under established policies of his Society). One reporter complained that "All I wanted to know was whether the [gunshot] victim was alive, dead, or critical. The nurse wouldn't say, the hospital superintendent couldn't be found, and the physician couldn't be reached until after our deadline." "And anyway," he added, "we really didn't ask or expect the intimate details!"

With the concurrence of the Council on Professional Relations (Colorado State Medical Society), the following suggestions are offered to facilitate more active and comfortable cooperation between physicians and our friends (and others) of the mass media:

1. As a matter of policy, organized medicine supports and encourages the ethical contribution by individual physicians toward dissemination of medical information and understanding, including *via* the mass media and lay groups.

2. No restriction is intended of the physician's right to express his own views in public, so long as (unless authorized) he clearly speaks as an individual and not for his profession.

3. Official statements for organized medicine are normally voiced by appropriate officers of the constituent society, or cleared by a society officer or member of the Publicity Committee.

4. Members who anticipate potential involvement in public controversy are encouraged for their own protection to seek counsel and support from their Publicity Committee or constituent society officers, to whom then any later criticism may be referred.

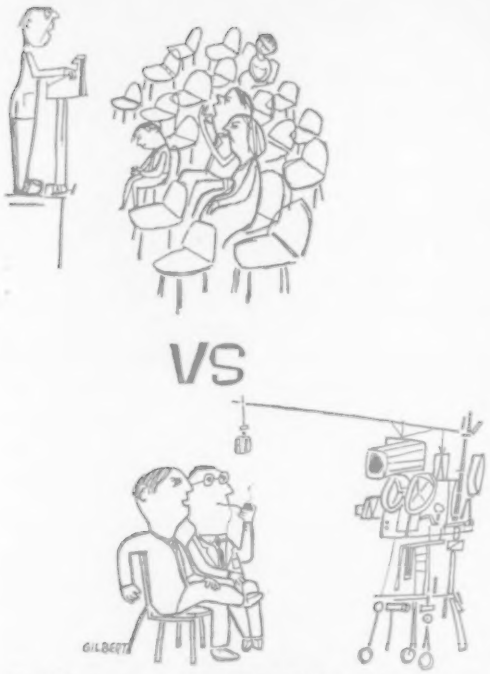
5. Some publicity *via* mass media may overlap local Society boundaries and accordingly merit consultation between County and State Societies, between State Societies or with A.M.A.—either for counsel and "clearance," or as a courtesy to insure coordinated public relations. Generally, of course, the local County Society exercises primary jurisdiction, referring such matters for counsel as are doubtful or to be broadly disseminated.

Certain technics and problems are peculiar to specific media, as for example:

1. News media (press, radio, TV) are dominated by time requirements and deadlines, and only rarely can accede to the understandable desire of the physician to recheck his quoted statements before release. Some tact, by the way, is due our friends of the fourth estate in this regard, lest our caution or distrust be interpreted as "censorship." By somewhat unfair analogy, the physician would feel his competency questioned were his patient to demand the right to proofread his own history and diagnosis before their entry on the hospital chart.

2. A physician may properly decline to be identified by name or directly quoted in professional statements—most logically when such identification adds little to the value of the story. I know of no instance locally in which requested anonymity has been violated by the media, although stories may well be dropped if unduly handicapped or invalidated by the physician's refusal to stand openly behind his assertions.

3. Anonymity of physicians appearing on radio is clumsy; on television is usually impossible or absurd. After introduction by name, however, ethical taste dictates that usually only a single additional identification be made (*e.g.*, member or



President of ——— Medical Society; clinical professor of ——— University; doctor of medicine in private practice)—avoiding fulsome labels such as "expert," "eminent roentgenologist," or "noted otorhinolaryngologist." Identification as a specialist or as an affiliate of a particular private clinic may on occasions be necessary to qualify the authority—but tends to detract from his primary image as a physician, *per se*.

4. In all media it is to be hoped that the physician's paramount objective is factual communication. This requires that he be more understandable than erudite, more concise and general than detailistic and circumstantial. It requires that he be cautious and objective in controversy, that he carefully label his personal opinions as such.

So anxiety-producing is the physician's unaccustomed role in the limelight of the mass media, it is inconceivable that more than a few of the profession would seek or welcome it (hospital cloak-room opinions to the contrary). The possible hazards of misinterpretation, embarrassment, and ill-conceived criticism from lay-public or one's colleagues all conspire to impel each of us to wish that someone else "better" would do it. Yet in over four years of serving on committees nominating television participants, I know of only one physician who refused the chore—and only one who felt compelled to withdraw (at preliminary rehearsal). Conversely, the physician can feel rewarding satisfaction after melding his professional knowledge with the vast potential of television to inform and visualize—this with effectiveness and scope never approached in a thousand P.T.A. lectures laid end to end. At once, TV's peering lens exposes the nervous smoker, exaggerates one's girth—but it also permits an intimacy of communication, the minute visualization of an operative field far surpassing that of the best-equipped lecture stage or closest surgical assistant.

Summary

In summary, our profession's mandate for effective medical public relations is to be found in Congress's legislative calendar, in the clamor of social pressure-groups for transcending "security" at any sacrifice (by others), in the lay hunger for medical information (all too often contaminated by fads and quackery). Survival of private medical practice in this country may well hinge upon the sustained efforts of individual physicians to validate and project a healthier image of their profession — through the practice of medicine of the highest quality, coupled with a personal sense of responsibility for constructive public relations ranging from individual contacts to utilization of (and cooperation with) the vast capabilities of the mass media. Or to borrow, with thanks, Moses' format:

1. Thou shalt accept responsibility for constructive medical public relations as inherent in the physician's mission—yea, even for his survival as a private practitioner—not excluding cooperation with the mass media.

2. Thou shalt not be evasively "unavailable" when awkward questions of fact arise from the news media.

3. Thou shalt not expect absolute clarity and understanding when our own (or a colleague's) pronouncements lose accuracy in translations from intent to medical jargon, then from medical jargon into print or broadcast.

4. Until ye become infallible and omniscient, thou shalt not resent controversy, denial, resistance, or criticism met among the unconvinced or uninformed. Indeed, they are our real challenge.

5. Thou shalt exhibit charity and tolerance toward those colleagues who try the difficult Public Relation assignments in the limelight. Ye might be next! ●

Closed-chest cont. from page 34

The promptness of initiating this method may make all the difference between recovering a normal individual, and either losing the patient or salvaging one with critical brain damage.

A certain amount of air is moved by the method. Therefore, if only one person is available, it may be started immediately. Attention to the adequacy of the airway may be delayed until further help arrives.

Once the method is begun, it may be continued for several hours, providing time necessary to bring the accessory equipment for stimulating resumption of independent heart rhythm. It is even hoped that as rescue units become familiar with this technic it may be used where necessary on patients being transported to the hospital. It has been thought to be of sufficient importance in this hospital that the entire nursing staff is being trained to carry on the method until medical help can be summoned.

Summary

In three instances, closed-chest cardiac massage was successfully used during sudden ventricular fibrillation. Definitive treatment with an external defibrillator restored an independent heart rhythm. The practicability of educating ancillary hospital personnel in the use of this method is illustrated. The importance of starting this technic promptly, by the first person to see the patient, is emphasized. •

Nodular tertiary cont. from page 29

nine million units of the drug. The cutaneous eruption responded rapidly to treatment and 14 days after the initiation of therapy was hardly discernible (Fig. 5). Thirty days after penicillin therapy was started, only a thin atrophy of the skin marked the site of the previous eruption (Fig. 6). Three years after the completion of therapy, the patient is asymptomatic, has no clinical evidence of neurosyphilis, and exposure of his arm to sunlight has produced no recurrence of the eruption.

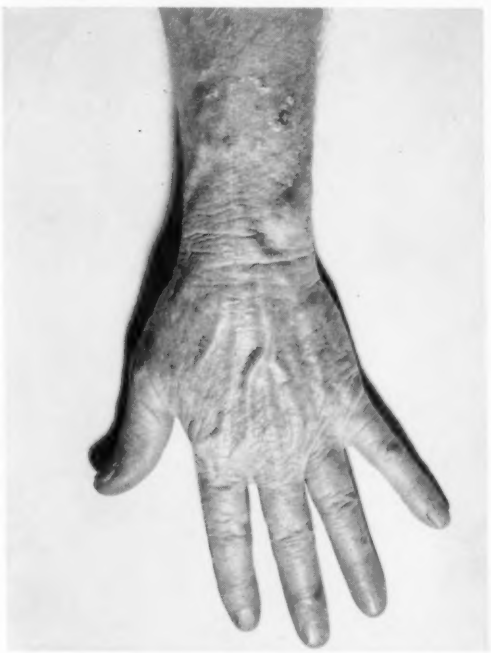


Fig. 5. Appearance of forearm 14 days after beginning of penicillin therapy. Healing has progressed. The ulcer is site of biopsy.

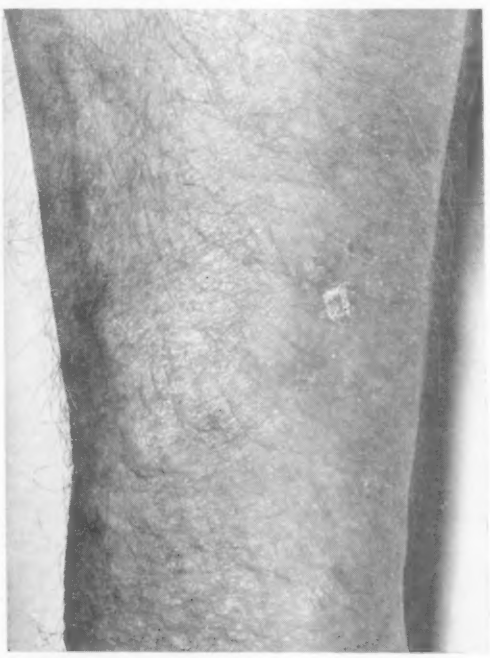


Fig. 6. Appearance of forearm 30 days after beginning of therapy and 10 days following completion of nine million units of procaine penicillin G.

Discussion

Within recent months, reports of cutaneous late syphiloderm have appeared in the literature. Robbins and Kirch[5] reported skin ulcers occurring on the left knee of an 87-year-old woman which had persisted for six months since an injury. These lesions were two punched-out ulcers, 2 x 3 cm. in diameter and 1 cm. in depth, indurated, and with brownish, peripheral pigmentation. The serologic test for syphilis was strongly positive and the cerebrospinal fluid test was negative. Of eight pregnancies experienced by the patient, there were no living members and only her oldest son had survived to the age of 39 years. It was postulated that she probably produced luetic children but that the delay in diagnosis was explained by the fact that her last pregnancy antedated the availability of serologic diagnostic procedures. The ulcers healed with use of 1,200,000 units of penicillin daily for three weeks.

Pinkus and Plotnik[6], in 1958, described the unusual occurrence of a syphiloderm on palmar aspect of one hand that healed with destructive alteration in the ridged surface pattern of epidermis and obliterated identifying features of fingerprints.

In 1956, Perry and his coworkers[7] at the Mayo Clinic felt that the problem of syphilis today was chiefly concerned, in relative absence of early syphilis, with evaluation of positive serologic tests for syphilis. While they recognized the great drop in the incidence of syphilis, generally speaking, they were of the opinion that because of infrequency of seeing clinical syphilis this disease is omitted in differential diagnosis of patients with obscure signs and symptoms. In our case, the clinical appearance of the lesion, serological test for syphilis, microscopic examination of tissue, and response to treatment clearly established the proper diagnosis. Stokes and his associates[8] have long been considered authorities on syphilology. They list ten basic physical characteristics of late syphilid which follow: (1) solitary character, or at least the presence of a few lesions; (2) asymmetry, though by no means invariable; (3) induration, deep palpable infiltration; (4) indolence, a relatively low grade eczematoid process; (5) arciform configuration, borders polycyclic or forming segments of circles, both in individual lesions and in configuration of a group of lesions; (6) sharp margination of lesions and ulcers have punched-out appearance; (7) tissue destruction and replacement, with and without ulceration; (8) central or one-sided healing with peripheral extension; (9) scar formation, superficial, atrophic (thin and wrinkled), noncontractile, the scar retains the arciform configuration of the original lesion; and (10) peripheral hyperpigmentation of a rather persistent type.

Small gummata are essential parts of tertiary syphilitic skin lesions. According to whether they are still in the tumor stage or whether a few or all have ulcerated determines three varieties which are described: nodular, nodulo-ulcerative syphilid, and the simple gumma.

The nodular syphilid may appear as early as three to five years following the initial infection or may not appear until several decades have passed. The primary lesion is small, pale red or brownish-red, pea-sized or larger, slightly elevated, painless, and infiltrated with rounded contours. In the course of development, new lesions appear peripherally while healing of the older, more centrally placed lesions takes place. Peripheral spread does not proceed equally in all directions and, instead of the circinate lesions which are characteristic of some forms of secondary syphilis, there are gyrate, polycyclic, segmented, or irregularly grouped lesions. On healing, there is a mild atrophic appearance with pale white, soft, smooth scars, most of which are surrounded by an area of hyperpigmentation.

The nodulo-ulcerative syphilid resembles this lesion except that ulceration has occurred.

The simple gumma has always been considered the classical lesion of tertiary cutaneous syphilis. In this case, the lesion may or may not have ulcerated. If untreated, it generally goes on to ulceration and a thick gummy material is released. Eventually, the opening increases in size and there is a deep, punched-out ulcer with perpendicular borders and an indurated, dull red base. The lesion develops over a relatively short period of time, several weeks to several months, and when fully developed may remain for many years. It is usually a painless lesion

until it encroaches upon nerve trunks or becomes secondarily infected or is in the vicinity of a joint.

Our patient had been diagnosed for several months as having a papular and prurigo-like type of solar dermatitis on the dorsal aspect of left forearm. He also attributed his difficulty to the fact that his forearm was exposed to sunlight when he would put it out of the window of his car while driving.

Lamb and his associates[10] have made a tentative classification of the light-sensitive skin eruptions which follows: (1) plaque-like type; (2) contact eczematous type; (3) papular and prurigo-like type; and (4) erythematous type—erythema solare perstans. It was the third of these types that our patient closely resembled. This type of prurigo aestivalis is characterized by recurrent eruptions of prurigo-like papules on areas exposed to light which are primarily the face, neck, hands, arms, and the V of the neck. The first symptoms are usually burning and itching of the skin, followed by erythema and some degree of urticaria-like swelling. Areas of involvement are generally diffuse and, if on the face, lesions usually involve the entire cheeks or sides of the neck. If lesions of prurigo aestivalis are on arms, they are generally on dorsal aspect and show lichenification and excoriation. Epstein[11] referred to a confluence of several lesions as "prurigo a grosses papules." First symptoms are burning and itching, followed by erythema with more or less urticaria-like swelling. The disease usually begins in early spring with the first sunny days, lasting until fall. In some cases, eruptions occur in winter following exposure to sun. Our patient noted no difference in eruption either in summer or in winter. Epstein[11] showed pictures of his Case No. 5 with the disease involving dorsum of the hand, similar to our case. Our case did not show characteristic findings of prurigo aestivalis since the lesions itched only slightly and did not return to normal during winter. Also, our case did not show profuse lichenification which is usually the case as a result of persistent scratching.

Lamb and associates[12] discussed clinical differentiation of plaque-like polymorphic light eruptions from discoid lupus erythematosus and remarked that papular and prurigo type of light eruption does not offer any confusion with that disease. In a discussion of the article by Lamb, Dr. Leslie M. Smith of El Paso, Texas, mentioned frequent predominance of polymorphic light eruption on the left side, presumably from greater exposure of that side when driving. Lamb also stressed this point. This was probably the prime reason that our case had an erroneous diagnosis attached.

Our case was unusual in that neurosyphilis was present at the same time as late cutaneous syphilis. O'Leary[13], in reporting one of the earliest cases of late cutaneous syphilis treated with penicillin, remarked, "It is not common to find a patient who has a late syphiloderm and a positive reaction of the spinal fluid for syphilis; in fact, such circumstances are rare." Most authors agree with this view and it has also been our experience.

Summary

A case of nodular tertiary syphiloderm of the skin is presented, which was, for a time, confused with papular and prurigo aestivalis type light sensitivity dermatosis. The case was diagnosed by paying particular attention to the morphology of the lesion, positive serologic test for syphilis, characteristic pathological findings, and response to treatment. Asymptomatic neurosyphilis was also associated. ●

REFERENCES

[1]King, A.: These Dying Diseases: Venerealogy in Decline, Lancet, 1:651-657, 1958.

[2]Beerman, H.: Problems of Syphilis Today, Arch. Dermat., 78:174-180, 1958.

[3]Rein, C. R.: Present Status of Syphilis, New York State J. Med., 56:2563-2566, 1956.

[4]Wise, F., and Wolf, J.: The Late Cutaneous Manifestations of Syphilis, M. Clin. North America, 22:1261-1274 (September), 1938.

[5]Robbins, J. J., and Kirch, E. P.: Skin Ulcers Due to Tertiary Syphilis: Report of a Case, New Eng. J. Med., 260:233-235, 1959.

[6]Pinkus, H., and Plotnik, H.: Destruction of Fingerprint Pattern by Superficial Late Syphiloderm, Arch. Dermat., 78:744-748, 1958.

[7]Perry, H. O.; Kierland, R. R., and Magath, T. B.: The Clinical Problem of Syphilis Today, Minnesota Med., 39:717-722 (November), 1956.

[8]Stokes, J. H.; Beerman, H., and Ingraham, N. R.: Modern Clinical Syphilology: Diagnosis, Treatment, Case Study, 3rd Ed,. Philadelphia: Saunders, 1944.

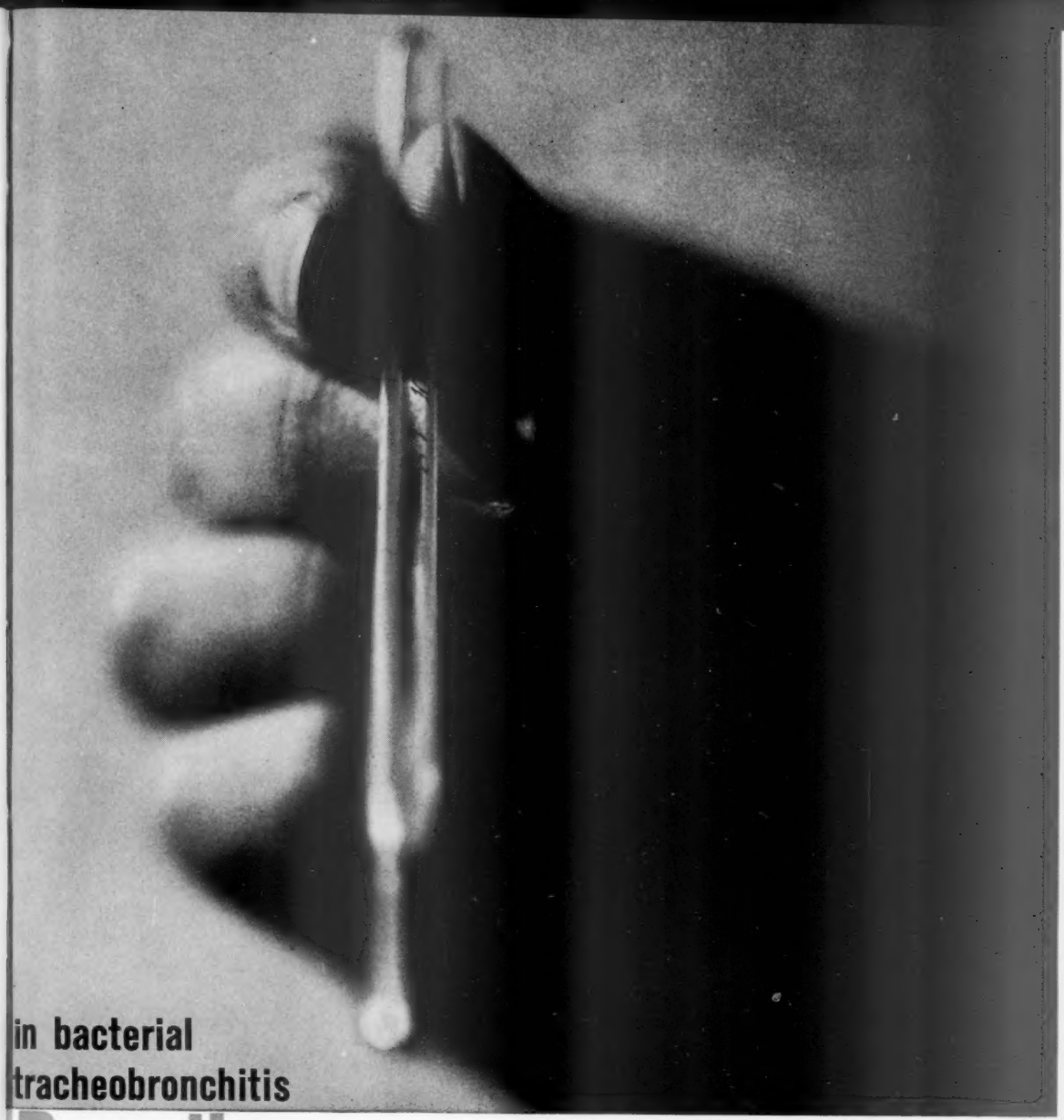
[9]Ormsby, O. S., and Montgomery, H.: Diseases of the Skin, 8th Ed., Philadelphia: Lea and Febiger, 1954.

[10]Lamb, J. H.; Shelmire, B.; Cooper, Z.; Morgan, R. J., and Keaty, C.: Solar Dermatitis, Arch. Dermat., 62:1-27, 1950.

[11]Epstein, S.: Studies of Abnormal Human Sensitivity to Light. I. Prurigo Aestivalis, Eczema Solare, and Urticaria Photogenica. Report of 17 Cases and Review of the Literature, J. Invest. Dermat. 5:255, 1952.

[12]Lamb, J. H.; Jones, P. E., and Maxwell, T. B.: Solar Dermatitis, Arch. Dermat., 75:171-180, 1957.

[13]O'Leary, P. A., and Herrell, W. E.: Penicillin in the Treatment of Late Cutaneous Syphilis: Report of Case, Proc. Staff Meet. Mayo Clinic, 19:20-22, 1944.



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Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently, a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
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been available. Their use has made the control of sodium and water retention much easier and has certainly contributed a great deal towards the reduction of the incidence and severity of toxemic pregnancy. In the last analysis, reduction of morbidity and mortality from this illness is the result of more intelligent prenatal care on the part of the doctor and more cooperation on the part of the patient.

In reviewing the perinatal[3] and maternal[4] death records, the Maternal and Child Welfare Committee came to the realization that a significant percentage of the mothers had received no prenatal care whatsoever. It, therefore, behooves those of us in medical practice, and in public health activities, to educate the laity to the importance of early and adequate prenatal care in order to further reduce our maternal and infant death rates.

Heart disease

Heart disease[5], which in some other sections of the country accounts for a goodly percentage of the maternal deaths, was responsible for only one maternal death, or 4.3 per cent, of this series. This particular patient had rheumtaic heart disease of severe degree and, in fact, had previously had a mitral commissurotomy. As is so often the case, cardiac failure in this instance was precipitated by a concomitant infection which was neglected by the patient.

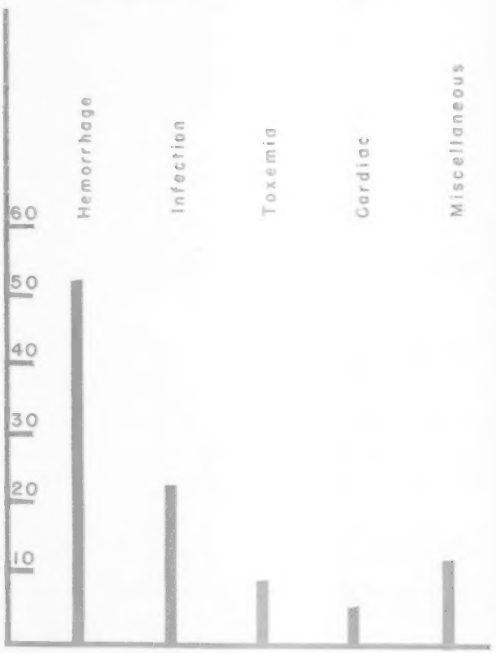
With the advances in our understanding of the physiology of pregnancy, it is known that the increased work load put upon the heart by pregnancy amounts to about a 30 per cent increase. We have also come to realize that this maximum work load occurs at approximately 28 weeks gestation. It is maintained at that level until approximately the 36th week and that during the last month of pregnancy this increased load significantly decreases prior to the onset of labor. There is again at the conclusion of the third stage of labor and for probably 24 hours thereafter, a sudden and sharp increase in cardiac output which imposes another burden upon the cardiovascular system. This knowledge has made it possible to give better care for a patient with rheumatic heart disease.

Particular attention must be paid to increased pulse rate, increased respiratory rate, persistent cough, during the times when the work load on the cardiovascular system can be expected to be increased significantly. The intelligent use of digitalis, diuretics, and antibacterial agents has further made it possible to reduce mortality from heart disease in pregnancy. It is particularly important to utilize antibiotics prophylactically during labor and for five to seven days postpartum in order to reduce the possibility of subacute bacterial endocarditis. Significant attention must be paid to adequate bedrest subsequent to delivery and ambulation must not be undertaken at too early a date.

Miscellaneous conditions accounted for three deaths or 13 per cent of our series of 23 patients. The first of these was a patient who did not see her physician until in extremis. She died at four and one-half months gestation with extreme electrolyte imbalance following hyperemesis gravidarum. The pathologic report also indicated the presence of Guillain-Barré syndrome. The second of these three patients who had had no prenatal care, approximately eight months pregnant,

GRAPH 2

Percentage of maternal deaths



was discovered dead at home by her husband. The pathologic report indicated that this patient had regurgitated and aspirated gastric contents resulting in her asphyxia. The third of these patients died from a pulmonary embolus while in the hospital in the early puerperium. This latter deaths points out the necessity for being ever watchful for signs of phlebothrombosis and thrombophlebitis.

Responsibility and preventability

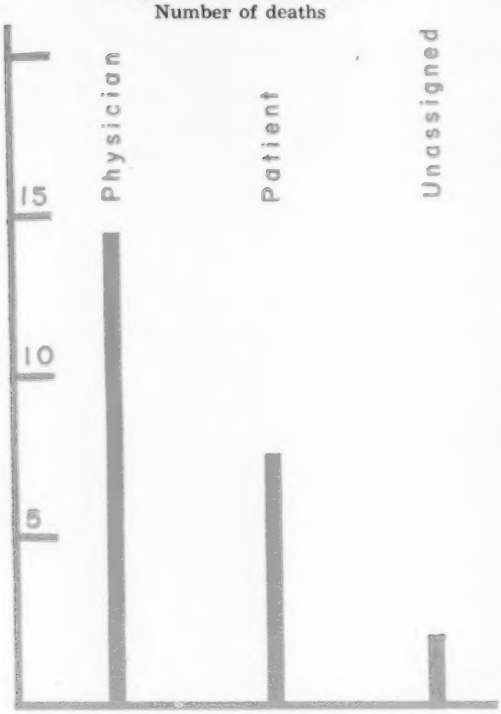
If learning and profit from an analysis of maternal mortality is to come, it is important to do two things: (1) try and establish responsibility for the particular death; (2) attempt to determine whether such a death is or is not preventable.

In subjecting this series of patients to these considerations we find the following: (1) Responsibility—it was the opinion of the committee that in 14 instances the physician in charge was responsible for the death involved; in seven instances responsibility was assigned to the patient. In two instances responsibility was unassigned because the committee was unable to adequately determine, from the facts, where to place the responsibility. (2) Preventability—the committee felt that 16 of these 23 deaths were definitely preventable.

GRAPH 3

Responsibility for deaths

Number of deaths



Conclusions

In conclusion, Montanans can be proud that the state's maternal mortality rate is and has been lower than that for the nation as a whole.

However, from the facts presented, this record might be even better. In 60 per cent of these deaths, responsibility for them was assigned to the physician in charge, and 70 per cent of these deaths have been classified as preventable. Therefore, it behooves the physicians of the state to pride themselves in continuing education; to keep up with at least some of the literature in the field, and to regularly attend medical meetings at which viewpoints can be broadened and new ideas acquired.

Too many hide behind the excuse of the demands of a large practice, but who can afford to be too busy to take adequate care of his patients? Education of patients is important, for who of them will seek adequate medical care if they are not brought to realize the benefits of modern medical practice.

It is in this field that the public health nurse may play a definite role, by encouraging adequate prenatal care, counseling with the expectant mother, and helping to prepare the patient for labor and delivery. Public health nurses as well as registered nurses are now conducting "Preparation for Parenthood" classes for high school students and expectant mothers in many parts of the state, and planned in others. Their educational value is without question.

The sad fact that almost three-fourths of the 23 maternal deaths were preventable should stir all on to the goals of continuing education, better care, and better results. •

REFERENCES

[1]Vital Statistics Special Reports, National Bureau Vital Statistics, Washington, D. C., 1957.

[2]29th Biennial Report, Montana State Board of Health, 1958, Helena, Mont.

[3]Perinatal Death Studies, 1954 through 1958, Montana State Board of Health, Helena, Mont.

[4]Maternal Death Studies, 1954 through 1958, Montana State Board of Health, Helena, Mont.

[5]Eastman, N. J.: Williams Obstetrics, ed. 11, 1956, Appleton-Century-Crofts.

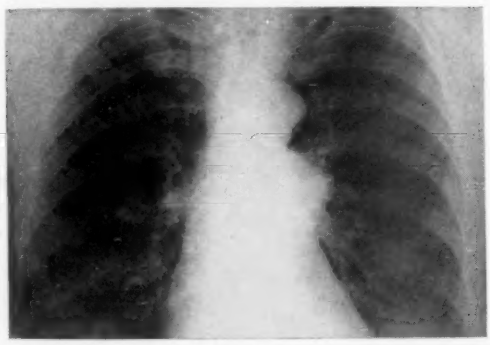


Fig. 3. Thymoma presenting as anterior mediastinal mass. Myasthenia was not associated with this tumor which proved to be malignant.

Thymomas represent one of the most interesting, and most poorly understood, facets of oncology (Fig. 3). Composed of epithelial and lymphoid elements, possessing undefined hormonal activity, bearing an obscure relationship to myasthenia gravis and erythroid aplasia of the bone marrow, and making a poorly defined transition from benign to malignant forms, the thymoma is an enigma of pathology. Histologically, the thymocyte is indistinguishable from the lymphocyte. Bioassay of acetone extracts of the thymus reveal it to be so rich in potassium that isolated muscle contractions are completely inhibited when the extract is added to the isolation bath. Since the initial report in 1901 by Laquer and Weigert[10] of a thymoma occurring in a patient with myasthenia gravis, many attempts have been made to define the relationship between the gland and the myoneural disorder. The observation by Mary Walker in 1934[5] that the curare antidote, eserine, also improved the muscle tone in a patient afflicted with myasthenia suggested to many that the thymus might produce a curare-like substance. No such thymic extract has been found. Wilson and Schwartz[6,8] have identified a depressant substance present in many myasthenic thymic glands, but also in extracts of normal lymph nodes and voluntary muscles.

Myasthenia and thymomas

In 1939, Blalock reported a marked clinical improvement in a myasthenic following the surgical removal of a thymoma. The operation gained wide favor in this country and in Europe, but subsequent clinical evaluations of the efficacy of thymectomy in myasthenia were contradictory, and the procedure fell into some disrepute. Recent statistical analysis of a series of 404 cases over a 25-year period[11] have shown there is a substantial chance for improvement after thymectomy in all cases of myasthenia gravis. This is most evident, and the saving of life is greatest, when the duration of the disease is less than five years and no thymoma is present. Improvement occurs in both sexes, but the extent of improvement is most significant in women as they would otherwise have a poorer prognosis than men.

Lymphoid hyperplasia is the most prominent histologic change in the thymus associated with myasthenia gravis, and is manifest by the formation of germinal centers in the medullary portion of the gland. In keeping with the contradictory nature of the thymus, there does not seem to be any correlation between the number of lymphoid follicles and the clinical course of the myasthenia gravis, although those patients with the fewest follicles in the operative specimen appear to have a poorer prognosis for improvement after thymectomy. Also, patients with myasthenia show a lesser degree of thymic involution when compared with the normal for their age and sex. The combination of lymphoid hyperplasia and retarded involution would perhaps explain the finding of thymoma in 30 per cent of all patients with myasthenia gravis.

Surgery in myasthenia

While the operative technic is not difficult, the preoperative preparation and the postoperative care of the myasthenic patient requires particular attention. Evaluation of thyroid activity and normal erythropoiesis should be determined in every case before scheduling for operation. Preoperative medication should avoid respiratory depressants, and the patient should be maintained on prostigmin administered by an intravenous drip for at least an hour before being taken to the operative suite. Cyclopropane administered by the endotracheal route is the anesthetic agent of choice, and muscle relaxants

should never be used. The operative approach is through a median sternotomy which obviates opening either pleural space and provides excellent exposure of the gland and its blood supply. The myasthenic patient salivates excessively and produces copious amounts of bronchial secretions both during and after operation; for these reasons a tracheostomy should be done before returning the patient to the ward. Postoperative discomfort, and the muscular weakness of the myasthenic may alter the ventilatory exchange sufficiently to warrant the use of a respirator in the initial postoperative course. Prostigmin should be given as an intravenous drip after thymectomy for more accurate control of the patient's requirements. The signs of both overdosage and inadequate administration of prostigmin are quite similar, but can be differentiated by giving one ml. (10 mgm.) of Tensilon® intravenously and noting whether the patient is improved or made worse. ACTH or cortisone will frequently induce a myasthenic crisis and should be avoided. The elevated blood levels of these substances following the stress of thymectomy perhaps accounts for the difficulties encountered in the postoperative management. Enemas should be avoided for fear of initiating a crisis, and sedatives and narcotics should be used in particularly small doses and with great caution. Finally, the full benefits of thymectomy for myasthenia gravis may not be manifest for 12 to 18 months following operation.

Thymoma occurring in non-myasthenic patients present equally unusual characteristics. There is no apparent histologic difference between the benign tumor, and those exhibiting invasion of the thymic capsule, adjacent vital structures and causing the death of the patient. At least 25 per cent of all thymomas exhibit those characteristics of invasion by direct extension attributed to malignant tumors, but a review of the literature fails to elicit a substantiated case of spread outside the thoracic cavity by lymph node or blood borne metastasis[2, 9, 12]. In thymoma showing invasion, mitoses are extremely rare and nuclear atypism or hyperchromatism most infrequent. Not uncommonly, malignant lymphomas, notably Hodgkins disease, may arise primarily in the thymus, and exhibit no known clinical differences from their counterparts in other lymphoid organs. The radiographic demonstration of an anterior mediastinal mass should alert the examiner to this possibility and a search made of the neck, axilla, and groin for additional adenopathy. A biopsy obtained from one of these sites may obviate a mediastinotomy if a lymphoma is found (Fig. 4).

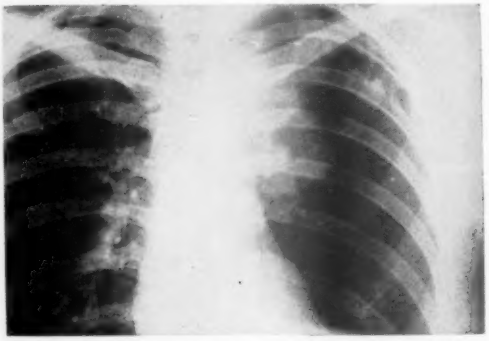


Fig. 4. Hodgkins disease of the anterior mediastinum. No other lymphadenopathy. Diagnosis made at thoracotomy.

Anterior mediastinum

Malignant tumors of the anterior mediastinum frequently manifest themselves by symptoms of anterior chest pain, cough, hemoptysis and respiratory distress. When combined with a radio-opaque shadow they represent a sinister syndrome requiring early diagnosis and vigorous surgical and radiation therapy.

Pericardial cysts (spring-water cysts) occupy the anterior - inferior mediastinum. Lined with flattened mesothelial cells, they represent a failure of the celomic lacunae to fuse. Frequently they achieve huge dimensions (18 cm. in diameter) and may cause respiratory distress. They are easily separated from the pericardium, and should be removed.

Less commonly encountered mediastinal tumors include fibrous displasia of the paravertebral portion of the ribs. Encroaching on the mediastinum, they may be mistaken for osteogenic sarcoma. Lipomas, though rare, occasionally arise in the mediastinum or even less frequently represent an intrathoracic extension of a subcutaneous lipoma. Encroachment on the pulmonary parenchyma

can result in extensive atelectasis.

Leimyomata of the posterior mediastinum arising from the esophagus are infrequently found. Because of the histologic similarities with neurilemoma including nuclear pallisading, it is conceivable that these tumors are more common than previously supposed but misdiagnosed as neurogenic tumors.

Aneurysms of the ascending aorta and aortic arch may be difficult to differentiate from solid tissue masses in the anterior mediastinum, especially in the absence of a luetic history (Fig. 5). Thickened aneurysmal walls may dampen pulsations and compound the diagnostic difficulties. Obviously, biopsies of undiagnosed tumor masses in these areas are to be avoided.

About 5 per cent of parathyroid adenomata will be found in the anterior-superior mediastinum. When a thorough search of the neck fails to yield a parathyroid tumor, the surgeon should not hesitate to enter the anterior mediastinum, particularly if the diagnosis of hyperparathyroidism is well established. Tumors or hyperplasia of the thyroid commonly extend through the thoracic inlet into the superior mediastinum. Usually these ectopic extensions can be delivered through the routine collar incision, but if the extensions pass posterior to the inominate vessels, discretion may dictate a medistinotomy to facilitate dissection.

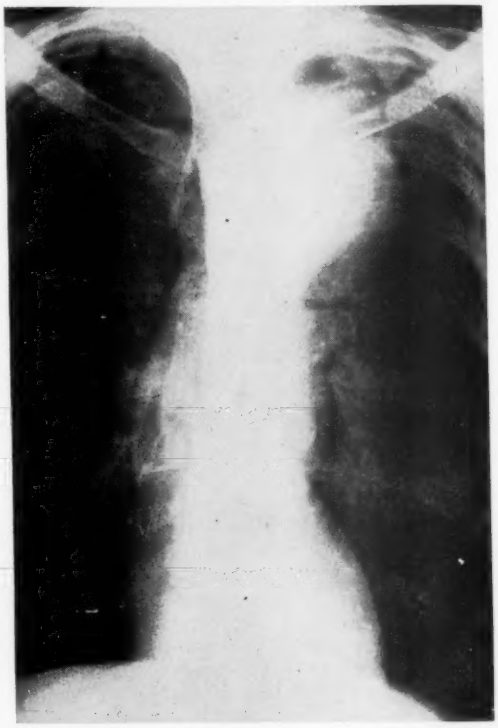


Fig. 5. Aneurysm of the arch of the aorta. This aneurysm was on the basis of arteriosclerosis, and had completely eroded the sternum.

Summary

Mediastinal tumors are almost always diagnostic problems, but their identification can often be surmised by their predilection for specific sites within the mediastinal compartments.

The various mediastinal tumors are discussed with particular reference to thymomas and their relationship to myasthenia gravis. The implication is advanced that all mediastinal tumors, with the exception of the lymphomas, are surgical problems and that their removal can be accomplished with minimal morbidity and low recurrence rates. •

REFERENCES

[1]Jacobs, E. M.; Hutter, R. V. P.; Pool, J. L., and Ley, A. B.: Benign Thymoma and Selective Erythroid Aplasia of the Bone Marrow. Cancer, 12:47-57, 1959.

[2]Lowenhaupt, E.: Tumors of the Thymus in Relation to the Thymic Epithelial Anlage. Cancer, 1:547-563, 1948.

[3]Rusby, N. L.: Demoid Cysts and Teratomata of the Mediastinum. A Review. Journal of Thoracic Surgery, 13:169-222, 1944.

[4]Hollingsworth, R. K.: Intrathoracic Tumors of the Sympathetic Nervous System. Surgery, Gynecology, and Obstetrics, 82:682-693, 1946.

[5]Walker, M. B.: Treatment of Myasthenia Gravis With Prostigmin. Lancet, 1:1200, 1934.

[6]Schwartz, H.: Discussion of Wilson, A., and Wilson, H.: The Thymus and Myasthenia Gravis. American Journal of Medicine, 19:697, 1955.

[7]O'Gara, R. W.; Horn, R. C., Jr., and Enterline, H. T.: Tumors of the Anterior Mediastinum. Cancer, 11:562-590, 1958.

[8]Wilson, A., and Wilson, H.: The Thymus and Myasthenia Gravis. American Journal of Medicine, 19:697, 1955.

[9]Iverson, L.: Thymoma: Review and Reclassification. American Review of Pathology, 32:321-345, 1952.

[10]Laquer, L., and Weigert, C.: Beitrage zur Lehre von der Erb'schen Krankheit uber die Erb'sche Krankheit (Myasthenia Gravis). Neurol. Zbl., 20:594, 1901.

[11]Simpson, J. A.: An Evaluation of Thymectomy in Myasthenia Gravis. Brain, 81:112, 1958.

[12]Fisher, E. R.; Coborn, D., and Effler, D. B.: Thymic Neoplasms. Journal of Thoracic Surgery, 24:58, 1952.

permit. The amount of radiation induced, no matter how slight, is not considered.

The blanket restriction thus placed on any induced radiation considerably narrows the sources of primary radiation that may be applied to the food product in the preservation procedure. Only those sources of radiation that do not induce radiation in the food product may be used. (Cg cobalt and x-rays of less than 8 mev.) This obviously limits the application of this technic to those foods in which penetration is no problem.

Another example may be found in the case of the addition of selenium to animal feeds. Selenium may not be added to feeds if the selenium finds its way into the tissues of the animal, later consumed by humans. However, wheat from a high selenium area may be mixed with feed to accomplish the same thing as free selenium.

Accidental exposure of foods to certain economic sprays is still another illustration. It would be in the best interest of all concerned if the users of economic sprays were constantly reminded to read and abide by the instructions for the use of the spray found on the label. The cranberry episode referred to previously would not have come about had the farmers followed instructions for use as printed on the label.

Meat and proteins

Meat products constitute the primary source of proteins for man and are, of course, of great importance to those living in the Rocky Mountain area where livestock growing is a major industry. Probably no article in the American diet is as much tampered with as meat. Take beef, for example. The average steak or roast probably comes from a cow born through artificial insemination, raised with an artificial sex hormone implant in its ear, fed synthetic hormones and antibiotics, sprayed with insecticides, and shot with tranquilizers. Yet after this chemical onslaught, when it is marketed and sold as meat, we have steaks that are bigger and better than ever. Cold meats and meat products may be subjected to additional chemical treatments before they go to the consumer. Agents used in this processing include preservatives and curing agents, antioxidants, flavored materials, coloring materials, emulsifiers, and refining and bleaching agents. All of these items, though, when used with discrimination, may improve the flavor and attractiveness of the meat.

Although we may not presently be concerned about the sources of adequate supplies of food, particularly inexpensive protein, it is important to think about such necessity for the future. Other countries can help supply protein-rich foods, which are exotic from our point of view, to help feed the world. They include milk made in Indonesia from soya powder, buffalo milk from India, fish-flour crackers from Chile, sesame seed crackers from Guatemala, peanut flour biscuits from India, spice cake made with cottonseed flour from Central America, flour from soybeans in many countries and sterilized milk is being greatly improved. All of these are high in protein and have long storage life in heat and humidity. This may help us solve the present world health problem of nutritionally deficient mothers producing less than healthy offspring who contribute to a high infant mortality.

Sanitary engineering

When one discusses sanitary engineering, first consideration is usually given to water pollution, air pollution and food sanitation. Lately, radioactivity in our environment has assumed equal importance.

WATER

The average rainfall is 30 inches. Seventy per cent returns to the atmosphere by evaporation or transpiration and is not readily available. We use less than 5 per cent of all that falls. Only 9 per cent of this is used as domestic water supplies, the other 91 per cent is evenly divided between agricultural irrigation and industrial cooling and power generating.

An important "must" for continued human progress is the availability of increasing supplies of good water. The ensewaged water dumped so as to contaminate most of the remaining quarter of all the water falling is rapidly diminishing our supply, as is also the careless treatment of the major watersheds. Among the essential goals are suitable treatment of ensewaged water so that it is suitable for human reuse, restoration of the ground water table by both conservative usage

and forced return, and conservation of the natural cover of our watersheds.

CARDIOVASCULAR DISEASE AND TREATED WATER

In the United States variations from state to state in death rates from cardiovascular diseases have been unexplained on dietary ratio or social bases. One variable environmental influence to which all persons are exposed is drinking water. Statistical analysis by H. A. Schroeder[8] of water hardness and death rates showed some factor, either present in hard water or missing from or entering into soft water, could conceivably affect death rates from degenerative cardiovascular disease. It should be noted that these correlations do not prove cause-and-effect relationships, but in the lay magazine article covering this J.A.M.A. paper, the heading was aptly "Hard Water—Soft Arteries."

AIR POLLUTION

Of increasing importance in the matter of human health is air pollution. In cities where air pollution factors are high, there is a positive correlation with higher death rates, seemingly dependent upon the chemical analysis of the local dust fall[9]. An interesting example to consider is the Loop area of the City of Chicago where in January, 1960, 124.1 tons of dust fell per square mile in a period of 30 days. Gaseous contaminants predominate in the air pollution of other communities. We are learning that our air supply is limited and must be conserved or its usefulness will be destroyed.

FOOD SANITATION

It is difficult, if not impossible, to estimate the amount and nature of disease caused by improper storage, processing, preservation, preparation, and serving of foods. In addition to the danger of contamination resulting from carelessness or ignorance, there is also the possibility of adulteration by unprincipled persons. Since the individual cannot protect himself against these hazards, it is a legitimate activity of government to provide the necessary protection by appropriate regulation, education and, when necessary, enforcement.

RADIATION HEALTH

The trends in the exploitation of nuclear energy make it clear that man-made ionizing radiation is a permanent addition to the hazards of human existence and well being[10]. Medicine has a grave responsibility to make the best possible estimates of the genetic injuries anticipated from small radiation exposures. In addition, we must furnish guidance and impetus to research programs so that improved future estimates can be made as soon as possible. Among the reported new findings that have a bearing on the assessment of the genetic effects of radiation are the following:

1. In animals, fewer mutations are produced in spermatogonia and oocytes by chronic irradiation than by the same amount of acute radiation when the total dose is the same.

2. Studies of human cells grown in tissue culture have shown that doses as low as 25 r will cause detectable chromosome breakage in a significant portion of the cells.

MAN'S OVER-ALL RADIATION EXPOSURE

Man is exposed to radiation from such man-made sources as medical and industrial x-ray machines, industrial applications of radioactive materials, radioactive fallout from weapons tests, radioactive waste materials and naturally occurring radio nuclides. From available evidence, medical exposures from x-rays constitute one of the major sources of radiation to man. This emphasizes the importance of the discriminating use of this modality as recommended by the American College of Radiology[11].

From an environmental health and safety standpoint, the types of potential waste management problems that will require continued surveillance and supervision in the future include releases of low-level wastes, possible leaching or relocation of small fractions of high-level wastes from underground storage sites, and accidental irregular releases from nuclear energy operations. Continued surveillance and monitoring is required to control build-up of contaminates in individual links of the food chain, from particular environmental concentration factors that might prevail.

LIFE SHORTENING

In animals it has been established that a shortening of life span may result from radiation exposure. In general, for a constant dose rate, the amount of life shortening increases as the radiation dose is increased. For a constant total radiation dose, the amount of life shortening increases as the dose rate is increased. There is evidence that the amount of life shortening depends on many factors such as genetic make-up, age and physical condition at the time of exposure. An increased incidence of leukemia has been found in such groups as atomic bomb casualties or those chronically overexposed (radiologists). Some have suggested an increased incidence of leukemia in children who have received prenatal diagnostic x-radiation.

DELAYED FALLOUT

At the present time, delayed fallout from the stratospheric reservoir is the major source of airborne artificial radioactivity. This will continue to be the case unless large scale testing is resumed. The most important isotopes in this debris are strontium-90, cesium-137 and carbon-14, both as carbon dioxide and as carbonates. The maximum concentration of strontium-90 occurs at 40-50° N latitude and is greatest in the spring and lowest in the fall. Most fallout is brought down by precipitation. Reasonable assumptions suggest that most of this will be down by 1962-63, when the ground

concentrations will be about twice those of November, 1958, if there are no further additions to the atmospheric burden.

Space medicine

Again using the reference of environment, we are also concerned with space exploration. What we're after, in essence, is a place for man to survive in encapsulated atmosphere, a cockle shell in space, or "terrella"[12]. Man's age-old physical and psychological needs, it seems, make him a rather poor risk for space voyaging. He simply must have many of the things that sustain him here below—air, food, and a certain amount of intellectual and physical activity.

Who would be the proper candidate for exploring outer space? Some have said the good space man might be found in cultures less time oriented and more sedentary, such as those from a Buddhist monastery or perhaps an Eskimo. Others feel that the extrovert who is more strongly oriented to people in the outside world can best stand being shut off. Women may be good candidates simply because they live longer than men. If spacemen, as seems important, must have not only good health, but also knowledge about health to avoid bringing disaster by physical incapacity, physicians might be ideal space travelers. Food probably will come from photosynthesis within the incapsulated space, possibly algae which contain protein, fat and carbohydrates. Other factors include learning about living without gravity, the disposal or utilization of body excretions, and how to recondition the air within an enclosed space.

Without gravity, we must think of muscular activity, much of which is related to the task of resisting gravity. Exercise would be difficult where the normal sense of balance will be deficient without the usual cochlear and kinesthetic stimulation. All phases of medicine will contribute to the success of conquering outer space. Psychiatrists will have to convince future spacemen that the hallucinations they may experience are the normal responses of isolated people. We will learn more about stress, for the man in space will be triggering the flow of adrenalin in some situations. Some scientists theorize that if a man were given small doses of the stress hormones, he might develop a tolerance for them and the dangerous effects of anxiety would be brought more or less under control. As one air force physiologist said, "Certainly a spaceman is going to get the quakes, but no worse than those poor wretches who were tossed to the lions in ancient Rome. A fellow can get just so scared and no more." Einstein, on the other hand, said, "The fairest thing we can experience is the mysterious. It is the fundamental emotion which stands at the cradle of true science. He who knows it not can no longer wonder, can no longer feel amazement, is as good as dead."

How can all this discussion of the interesting future ventures into space contribute to the practice of medicine here on "terra firma"? Perhaps it is important to remember what Alexis Carrel propounded when he said that "biologically in man, the things which are not measureable are more important than those which are measurable." In other words, let us now think about the concept of extending the boundaries of medical knowledge by greater application of our energies to the patients we see.

Summary

A thousand years of history shows five patterns of disease which characterize overlapping eras in the development of our understanding of the influence of environment on the health of man. Leprosy and plague, endemic for centuries, gradually subsided after the 14th century. Louse-borne diseases and syphilis became increasingly important toward the end of the 15th century. World War II was the first war not decided by louse-borne typhus and only recently has syphilis been considered controlable. Toward the end of the 19th century gastrointestinal diseases began to decline with the advent of sewage disposal, pure water and sanitary milk. Benefits from the bacteriologic studies of the late 19th century and early 20th century have improved the morbidity and mortality, not only of children but of adult groups as well. Stabilization of food supply and other factors caused a decline in tuberculosis even before the discovery of the bacillus. During the 20th century immunization

and more effective therapies have accelerated the decline of bacterial and virus diseases. Because the gastrointestinal and bacterial diseases have been controlled in children and young adults, more people have survived into the age groups associated with cancer, arthritis, and cardiovascular disease. Concern with these, and with the many aspects of allergy, endocrine dysfunction and the psychoses and neuroses indicate a fifth period which we are entering, if, indeed, we are not already in it. And, no doubt, other periods will follow with problems only suspected in the more advanced research laboratories.

My major theme for this paper is that private medicine, in cooperation with official and voluntary health agencies, can bring this nation nearer to the medical millenium by a study based on four factors which are related to this historical progression[13]. These are:

1. The characteristics of the population—its age and sex composition, birth rate and mortality rates;

2. The level of social and technical development — proportions of rural-urban residents — proportions in occupations such as agriculture, public service, commerce, industry;

3. The patterns of disease as measured by mortality—major problems, chief killing diseases, diseases disappearing or emerging;

4. The level of medical development—the nature of medical personnel, facilities and technology, prevailing theories of disease causation, methods of disease prevention and control, methods of treatment.

The environmental aspects of medicine range from a study of the individual body cell to the endless limits of outer space. As physicians and humanitarians, our obligations increase because of our knowledge and capability. By a better understanding of environmental medicine, we in private medicine can, together with all other allied health professions and services, bring more positive health to our communities and become the bridge between what actually now occurs and what can be done to raise the level of social performance. •

REFERENCES

[1]Marti-Ibanez, F.: Henry E. Sigerist on the History of Medicine. New York, MD Publications, Inc., 1960, p. 131 and following.

[2]Porterfield, J. D., Deputy Surgeon General, Public Health Service, Washington, D. C.: Personal communication.

[3]Martin-Ibanez, F.: Centaur. New York, MD Publications, Inc., 1960, p. 214.

[4]Emerson, H.: Selected papers. Battle Creek, Mich., W. K. Kellogg Foundation, 1949.

[5]U. S. Department of Health, Education and Welfare, Food and Drug Administration: What Consumers Should Know About Food Additives. Washington, D. C., 1960.

[6]American Medical Association: Statements and Decisions of the Council on Foods and Nutrition of the A.M.A., 1957. Chicago, Ill., pp. 4-5.

[7]White, Philip, Director, Department of Food and Drugs, American Medical Association, Chicago, Ill.: Personal communication.

[8]Schroeder, H. A.: Relation Between Mortality From Cardiovascular Disease and Treated Water Supplies. J.A.M.A. 172: 1902, 1960.

[9]Armour Research Foundation, Illinois Institute of Technology: Chemical Analysis of Dustfall Data—City of Chicago, Readings in Tons per Square Mile per Month of 30 Days. Chicago, Ill., Air Pollution Control, January, 1960.

[10]National Academy of Sciences, National Research Council: The Biological Effects of Atomic Radiation. Washington, D. C., National Research Council, 1960.

[11]Chamberlain, R. H.; Nelsen, R. J.; and The Commission on Units, Standards, and Protection of the American College of Radiology: A Practical Manual on the Medical and Dental Use of X-rays With Control of Radiation Hazards. Chicago, Ill., The American College of Radiology, 1958.

[12]Lang, D.: Man in Space. From Hiroshima to the Moon. New York, Simon and Schuster, Inc., 1958.

[13]Anderson and Rosen: An Examination of the Concept of Preventive Medicine. Research Series No. 12. New York, Health Information Foundation, 1960.

Editorial cont. from page 23

a reduced fee. What other segment of the population offers its services to the old age pensioner at a reduced fee?

Does the building industry offer its services to the old age pensioner at a reduced fee? Are lawyers, plumbers, carpenters, etc., asked to give their services to the old age pensioner at a reduced fee?

Mr. Pieper would do well to ponder these matters before he singles out the doctors as (to take his inference) profiting at the expense of the old age pensioners.

Our colleague has expressed our sentiments as well or better than we could. Many of us wonder why our profession is singled out to do more than its share in supporting the great give-away. It is strange that people in general will budget and save for almost anything except sickness, accident, or infirmity. Faced with the exigency, someone else must pick up the tab—specifically in this instance, the medical profession. Then he who is the beneficiary publicly denounces those to whom he is beholden. Another case in point: Look at the United States today, in the eyes of the rest of the world!

The Goodwill Evaluation Center—Help for the disabled worker

How can a patient, who is physically handicapped by reason of accident or illness, be helped to return to gainful employment? This is a question which most physicians ask at some time during their professional lives. In answering this question we must consider several factors. First, what are his physicial limitaitons? This, of course, can be answered by the physician. Then, what are the patient's own feelings and desires about returning to work? Also, what are his feelings and attitudes toward his handicap? Finally, what abilities, both developed and latent, does he have which make him employable?

The answers to those questions can be found through vocational evaluation. The Goodwill Evaluation Center has as its objective the evaluation of the assets and limitations of the physicially handicapped in terms of employment potential. The purpose of the Center is to provide a program of vocational evaluation which goes beyond the usual forms of interest and aptitude testing. The Goodwill Evaluation Center utilizes a modified version of the TOWER system of evaluation which was developed by the Institute for the Crippled and Disabled in New York City and is specifically designed for use with those who are handicapped by some form of physical disability. By combining this testing with actual job performance testing in the workshops of Goodwill Industries of Denver, a practical method of work evaluation has been accomplished. Testing and evaluation are done under the direction of specially trained personnel.

Provisions for work training and for help in adjusting to the demands of actual working conditions have been included in order to enable the clients to make adequate use of their abilities. Most of the clients evaluated by the Center have been referred through a State Division of Vocational Rehabilitation. However, referrals are also made by private physicians, by hospitals, by medical clinics, by insurance companies, by health agencies and by welfare agencies. Any person of normal intelligence, who is 16 years of age or older and who has a physical disability, is eligible for this evaluation.

There is no limitation as to the area from which a client may come, but the Goodwill Evaluation Center is particularly interested in serving handicapped persons from the Rocky Mountain States. For clients who do not live in the Denver area, the Goodwill Evaluation Center can help in arranging for board and room while they are at the Center. It is the policy of the Goodwill Evaluation Center to consult with the State Division of Rehabilitation on each client and to secure from the Division such services as are appropriate to the particular client. It is also desirable that a complete medical and psychological evaluation be done on each client before referring him to the Goodwill Evaluation Center in order that a realistic approach to the individual problem may be made.

For further information about the Center call AMherst 6-3771 or write to: Program Director, Goodwill Evaluation Center, 3003 Arapahoe Street, Denver 5, Colorado.

Doc Strike

In Japan, garagemen charge 22¢ to repair a punctured tire, while doctors get 15¢ for a medical checkup. Feeling understandably misused, the Japanese Medical Association last week called its members out on two 24-hour strikes and announced that Japan's 70,000 doctors would strike —and demonstrate—every Sunday until they get a 30 per cent raise in fees.

The striking doctors were careful not to leave Japan completely undoctored. Stand-by staffs were detailed to treat emergency cases in hospitals —but getting to the hospital was a problem. Firemen in Tokyo pressed 114 red fire engines into part-time duty as ambulances, made 523 stretcher calls. Despite all the sirens and confusion, only six deaths were attributed to the doctors' strike, and

in each case the patient was so far gone he would probably have died anyhow.

Target of the doctors' strikes is the health insurance plan, Japan's form of socialized medicine. Under the plan, an appendectomy brings $8.80, an abortion (legal in Japan) $2.62, an emergency night house call 34¢. The highest fee is $27.80, for delicate brain or heart surgery. As a result, 60 per cent of Japan's doctors earn less than $85 a month — even less than the average Japanese schoolteacher.

An even more bitter pill for any self-respecting medical man is the government's control over the treatment of every diagnosable malady. The Ministry of Welfare code prescribes every step. If, for example, a doctor suspects tuberculosis, he may x-ray, but can collect his fee (88¢) only if the results are positive.

Says the Japanese Medical Association's President, rotund Dr. Taro Takemi, who is leading the doctors' demonstrations: "It is unfortunate that the situation exists where a doctor must parade in the streets. I agree it is unethical from the broad human viewpoint, but doctors, too, are human beings."—Time, March 3, 1961.

Patterns of Disease

Some 25,000 to 43,000 Americans are likely to be afflicted each year with Parkinson's disease, and 2-3 per cent of persons in this nation's population may develop the disease during their lifetimes, according to *Patterns of Disease*, a monthly Parke, Davis & Company publication for physicians. The disease ranks second in the U. S. among all neurologic disease.

The Scientific Medical

(with apologies to the Shade of W. S. Gilbert)

I am the very model of the Scientific Medical,
I know each nerve and artery, each ligament and pedicle;
My knowledge has been built upon evolutionary processes
From Galen and Hippocrates to present-day Colussusses.

I've studied all the endocrines and know the various offices
Of pancreas and thyroid, or of thymus and hypophysis;
I know the suprarenals too, and all that they're related to—
How benighted were the medicos who lived in 1882.

I know the pH value of ionical acidity;
I calculate percentages with wonderful rapidity;
And when it comes to artery or ligament or pedicle
I am the very model of a scientific medical.

I'm particularly expert at a Wasserman analysis;
I hunt for protozoa in a patient with paralysis;
The chemistry of insulin's a subject that I revel in,
And antitoxin therapy I'm just the very devil in.

I know the role of calcium in various forms of tetany;
I understand trypanosomes, although I've never met any;
And I've the latest news on perineural sympathectomy,
My knowledge often bringing in a good substantial cheque to me!

I'm very strong on vitamins and matters dietetical;
I know the graphic formulae of remedies synthetical;
And when it comes to artery or ligament of pedicle
I'm just the very pattern of a scientific medical.
(more slowly)

When I've acquired some knowledge about matters pharmaceutical;
When I can diagnose a little deeper than the cuticle;
When simple indigestion has become a trifle clear to me;
When babies with the colic are no more a source of fear to me;
When I can write a recipe with ordinary galenicals,
When I have learned the doses of the various arsenicals;
When highbrow scientific lore no longer needs a missioner,
You'll then consult me safely as a general practitioner!

For my scientific knowledge, though I'm always up to date with it,
Has kept me back in practice, and I'm just a little late with it;
But when it comes to artery or ligament or pedicle
You'll find I'm just the model of a scientific medical.

Thomas Stephenson
(Thanks to Francis E. Bertling, M.D.)
From Bulletin, Spokane County Medical Society, January, 1961.

Notes on life expectancy

Although the white population in this country has a longer life expectancy at birth than the nonwhite, the differential is narrowing. In 1900, says Health Information Foundation, life expectancy for whites exceeded that for nonwhites by 14.6 years, but by 1958 this difference had been reduced to 7.3 years.

Colorado-Cornell automotive crash injury research program summary tabulations*

The following tabulations are based upon *rural* recent-model-year passenger car accident cases submitted to the Colorado-Cornell Automotive Crash Injury Research program by the Colorado State Patrol in cooperation with the Colorado State Medical Society and the Colorado Hospital Association. This program was coordinated in Colorado by the State Medical Society. These data were collected at the scenes of the accidents by officers of the Colorado State Patrol. Special report forms and photographs were submitted in each instance. Physicians examining injured persons completed a short medical report on the exact nature and degree of each injury sustained by the occupant.

In order for an accident to qualify for inclusion, an occupant of a passenger car had to be injured to some degree, or property damage had to exceed $200. The accidents ranged in severity from minor to extreme and the injuries ranged in degree from trivial to fatal. Reports were submitted on 2,757 accidents involving 2,916 recent-year model passenger cars. The number of occupants in all cars totalled 6,541. Of these, 3,074 (47.9 per cent) were involved in accidents in which someone was injured to some degree. The remaining 3,467 occupants (52.1 per cent) sustained no injury of any kind.

*The Colorado-Cornell Automotive Crash Injury Research program was conducted on a state-wide basis and was sponsored by the Colorado State Medical Society, in cooperation with the Colorado State Patrol and the Colorado Hospital Association, from July 1, 1957, to December 31, 1960.

"Notice how much more carefully he's driving now?"

—The Road Toll by The Travelers Insurance Companies, 1959

Rural accidents

Number of accidents reported in ACIR sample	2,757
Number of cars reported in ACIR sample	2,916
Number of injury-producing accidents	1,332
Number of cars reported in injury-producing accidents	1,368
Number of noninjury-producing accidents	1,425
Number of cars in noninjury-producing accidents	1,548

Total cars	Total accidents	Injury-producing accidents		Property-damage accidents	
		Cars	Accidents	Cars	Accidents
2,916	2,757	1,368	1,332	1,548	1425

Year of manufacture of automobiles in injury-producing accidents

1956	324
1957	608
1958	372
1959	64
Total	1,368

Occupants not ejected

(Total occupants in injury-producing accidents, 3,074)

Not ejected	2,713
Not injured	877
Minor and nondangerous	1,713
Dangerous	79
Fatal	35
Dangerous and fatal	4.2%

Occupants ejected

Ejected	362
Not injured	12
Minor and nondangerous	243
Dangerous	61
Fatal	46
Dangerous and fatal	29.6%

New method to calculate precise radiation dosage for cancer

Researchers at the University of Texas M. D. Anderson Hospital and Tumor Institute here are using an electronic computer to help them measure how long it is safe to leave radium needles in cancerous tissue. It is the first time that doctors have been able to calculate the precise radiation dosage for each radium implant given as a standard part of the radiotherapy routine. The new technic was reported on recently before the Radiological Society of North America by Dr. Robert J. Shalek, Ph.D., acting head of M. D. Anderson's Department of Physics. Co-author of his paper was Marilyn A. Stovall.

A difficult problem in treating cancerous growth by radiation is that too little exposure may result in failure to stop the growth. However, too much radiation is harmful. Previously, doctors have had to rely upon approximate calculations of how long to leave radium needles in during treatment. This is because it takes too long to solve the complex problems of dosage manually which must be worked out for each radium implant to learn the exact amount of radiation being absorbed each hour at every point in the treated volume.

A full-time technician could solve the problem in three to four weeks, but this is of little practical value since the normal radium implant remains only five to seven days. An IBM RAMAC computer, installed at the hospital primarily for accounting use, is solving the same problem in approximately four hours of computation time, Dr. Shalek reported. He said it is planned to use a faster computer, such as the IBM 1620, to do the same calculation in five minutes. In addition to giving the physician precise information which he never had before, Dr. Shalek said the rapid availability of these data may help radiotherapists improve implants by adding or changing placement of needles as indicated by the computer's figures.

In most cases today, doctors arrange radium needles in accord with various insertion patterns which have become standard. They then refer to charts which give dosage figures to a particular point for the various implant patterns. Because each implant (placement of needles) varies, doctors know that tabular methods are not accurate. Tissue next to needles receives maximum radiation, while that between needles receives less radiation, in varying degrees. The IBM computer will calculate dosage for at least 600 critical points instead of only one. Dr. Shalek hopes the hospital's use of RAMAC will improve radium dosage technics throughout the medical profession by providing more definitive information on what constitutes the ideal dosage and implant pattern for the different types of cancer. "We hope to develop isodose curves and charts for distribution throughout the profession," he says. M. D. Anderson is one of the nation's largest institutions dedicated to cancer research. It is a state-supported, university-managed hospital where patients are admitted by referral only. In the hospital's program of patient care, education and research, the Anderson staff plans to use RAMAC's 5,000,000 character memory and computing capacity in other phases of the hospital's program which currently includes more than 100 major, formalized research projects.

Patterns of Disease

Funds for research in Parkinson's disease, this nation's second most prevalent neurologic disease, have increased almost ninefold in the past five years, according to the April issue of *Patterns of Disease*, a monthly Parke, Davis & Company publication for the medical profession. Federal research budgets have risen from $114,168 in 1956 to $1,000,000 for the current year. In addition, the Parkinson's Disease Foundation, Inc., has contributed $310,000 to support some 50 research projects, and the National Parkinson Foundation, Inc., has earmarked $25,000 of a proposed research fund of $150,000 for similar projects.

THE BOOK CORNER

New books received

New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Medical Library soon after publication.

Beloved Professor: Life and times of William Dodge Frost, by Russell E. Frost. N. Y., Vantage Pr., 1961. 350 p. Price: $3.75.

The Chemistry of Immunity in Health and Disease: By David W. Talmadge, M.D., and John R. Cann, Ph.D. Springfield, Thomas, 1961. 178 p. Price: $5.75.

The Choice of a Medical Career: Essays on the Fields of Medicine. Philadelphia, Lippincott, 1961. 231 p. Price: $5.00.

The Human Frame: By Giovanna Lawford. Garden City, Anchor Books, 1952. 109 p. Price: 95c.

American Academy of Orthopaedic Surgeons Instructional Course Lectures, vol. 17, 1960. St. Louis, C. V. Mosby, 1960. 421 p. Price: $18.50.

Slice Reconstructions of Human Cerebral Sections: By Wendell J. S. Kreig, Ph.D. Evanston, Brain Books, 1959. Price: $1.00.

Squibb Product Reference for the Medical Profession: By E. R. Squibb & Sons, 1960. 269 p.

Stroke: A study of recovery, by Doublas Ritchie. Garden City, Doubleday, 1960. 192 p. Price: $3.50.

Surgical Diseases of the Chest: By Brian Blades, M.D. St. Louis, Mosby, 1961. 530 p. Price: $22.00

Blood Diseases of Infancy and Childhood: By Carl Smith, M.D. St. Louis, Mosby, 1960. 572 p. Price: $17.00.

CIBA Foundation Symposium on Haemopoisis: Cell production and its regulation. Boston, Little, 1960. 490 p. Price: $11.00.

The Gentle Legions: By Richard Carter. Garden City, Doubleday, 1961. 335 p. Price: $4.50.

Healthy Babies—Happy Parents: By Henry K. Silver, M.D.; C. Henry Kempe, M.D., and Ruth Svibergson, M.D. N. Y., McGraw, 1960. 228 p.

Importance of the Vitreous Body in Retina Surgery With Special Emphasis on Reoperations: By Charles L. Schepens, M.D. St. Louis, Mosby, 1960. 226 p. Price: $15.00.

Light Coagulation: By Gerd. Meyer-Schwickerath, M.D. St. Louis, Mosby, 1960. 114 p. Price: $9.50.

Respiration: Physiologic principles and their clinical application, by P. H. Rossier, M.D.; A. A. Buhlmann, M.D., and K. Wiesinger, M.D. St. Louis, Mosby, 1960. 505 p. Price: $15.75.

Clinical Psychiatry: By W. Mayer-Gross, M.D., F.R.C.P., and others. 2d ed. Baltimore, Williams & Wilkins, 1960. 704 p. Price: $13.00.

Infectious Diseases of Children: By Saul Krugman, M.D., and Robert Ward, M.D. St. Louis, Mosby, 1960. 398 p. Price: $13.00.

Letters to My Son: By Wendell J. S. Krieg. Evanston, Ill., Brain Books, 1960. 85 p. Price: $3.00.

Medicine as an Art and a Science: By A. E. Clark-Kennedy, M.A., M.D., F.R.C.P., and C. W. Bartley, M.A., D.M., M.D., M.R.C.P. Philadelphia, Lippincott, 1960. 425 p. Price: $6.25.

Progress in the Treatment of Fractures and Dislocations, 1950-1960: By Thomas B. Quigley, M.D., and Henry Banks, M.D. Philadelphia, Saunders, 1960. 102 p. Price: $2.50.

The Question of Fertility: By Georges Valensin, M.D. Garden City, Doubleday, 1960. 246 p. Price: $4.50.

Resuscitation of the Newborn Infant: Edited by Harold Abramson, M.D. St. Louis, Mosby, 1960. 274 p. Price: $10.00.

The Senescent in Industry: Medical management of his employability and health maintenance, by George C. Dowd, M.D. American Geriatrics Society, 1960. 94 p.

The Surgical Treatment of Portal Hypertension, Bleeding Esophageal Varices and Ascites: By M. Judson Mackby, M.D., D.A.B.S., F.I.C.S. Springfield, Thomas, 1960, 250 p.

Book reviews

Babies by Choice or by Chance: By Alan F. Guttmacher, M.D. Garden City, New York, 1959. Doubleday & Company, Inc. 289 pages. Price: $3.95.

Much of what we read about the population problem of the world stems from the writings of Dr. Guttmacher. In a clear, easily readable, succinct manner, this well qualified obstetrician-gynecologist discusses contraception: why and when it is necessary; available methods; and medical, legal and religious attitudes toward it.

By the author's admission, it is an "indignant book"! He deplores the fact that "man is his brother's keeper when it comes to the prevention of polio or smallpox but not when it involves preventing a pregnancy." And he clearly points out that contraceptive advice commensurable with the patients' needs and religion are available to those who can afford a private physician, but not to those who most need it and cannot.

Sterilization and the various aspects of the abortion problem are also well discussed in detail, as are infertility and artificial insemination. All phases of each are covered with interesting and illustrative case histories to punctuate them.

Although certainly written for the lay individual, many, if not all, physicians would profit greatly from reading this interesting book. These problems of society indeed concern all of us.

Walter J. Grund, M.D.

The Surgical Treatment of Portal Hypertension, Bleeding Esophageal Varices and Ascites: By M. Judson Mackby, M.D., D.A.B.S., F.I.C.S. Springfield, Illinois, Charles C. Thomas, 1960. 250 p.

Dr. Mackby has presented his subject completely, succinctly, and interestingly. Within this relatively short monograph one finds the entire surgical aspect of portal hypertension arrayed in a logical fashion from pathologic physiology to postoperative care. The author prefers the end-to-side portacaval shunt as a means of portal decompression, but arrives at this decision following an objective analysis of the side-to-side and double-barreled shunts as well as the splenorenal anastomosis.

Hypothermic anesthesia is mentioned only cursorily. Perhaps, here in Denver, we might tend to give this adjunct to our operative armamentarium somewhat more emphasis.

Unique to this volume are two chapters devoted to the analysis of the experience and opinions of well known contemporary workers in this field.

All who are seeking information relative to

the problem, regardless of their extent of personal experience or degree of formal training, will find this volume to be most satisfactory.

Allan B. Kortz, M.D.

Contributions to Obstetrics and Gynaecology: By V. N. Shirodkar, M.D., F.A.C.S., F.R.C.S. Edinburgh, Livingstone, 1960. 159 p. Price: $8.50.

This little book, as the author refers to it, is not intended as a textbook; but rather as a contribution to the specialty. In review of the wealth of experience which Dr. Shirodkar has had, it must be assumed that his various operative technics would be of vital interest to those in this field of medicine.

The author writes in fair detail and in a concise manner when he discusses the various operative technics of others, his own experience with them, and finally his own methods. The operative procedures are well illustrated by black and white photographs and figures. He also writes of the percentages of successes and failures which he has found with various methods.

Of special interest appear to be the following procedures:

1. Operation for habitual abortion using Mersilene thread with beads.
2. Description of the Sherodkar Extended Manchester operation for prolapse of the uterus. Also, Shirodkar sling operation for prolapse.
3. Surgery of blocked fallopian tubes using polyethylene loop with a tantalum wire. Salpingostomy detailed, but brief.
4. Problem of artificial vagina.
5. Summary of various papers by the author re ectopic pregnancy and methods of diagnosing, postmenopausal uterine fibroids, treatment of chronic cervicitis, ventral suspension, chronic inflammation of fallopian tubes, ovarian cysts, functional uterine hemorrhage, rare conditions of the cervix and hysterectomies.

Part II, obstetrics, is a summary of various papers by the author dealing with the following subjects:

Puerperal inversion, caesarean section, breach with extended legs, persistent occipitoposterior, labor in elderly primiparas, management of threatened abortions, foetal heart, examination of the placenta, delayed postpartum hemorrhage, hematuria, induction of abortions, condylomata acuminata, and prevention of wound sepsis.

Last but not least in this excellent little book is the rare condition of epispadias in the female, showing black and white photographs together with details of repair.

Lawrence Mozer, M.D.

Synopsis of Pathology: By W. A. D. Anderson, M.A., M.D., F.A.C.P., F.C.A.P. St. Louis, C. V. Mosby Co., 1960. 5th edition. Price: $9.25.

After having read the book and having a degree as an M.D., I have come to realize that in the study of medicine, which is "an art of a science," the scientific part may be more easily gained by having read a good textbook of pathology, which I think Dr. Anderson has written. This fifth edition draws attention to the moderately rapid advance in the science of pathology. Some conditions previously known have been altered in aspect by new knowledge, have received new recognition, or gained importance.

It is a thoroughly informative book which has been reasonably condensed. I would recommend it for a student starting out in the study of medicine.

Lawrence Mozer, M.D.

The Gentle Legions: By Richard Carter. Garden City, Doubleday, 1961. 335 p. Price: $4.50.

This book gives an introduction to the various national voluntary health organizations in the United States. The "gentle legions" in the title refers to the 15 million volunteers who contribute time, interest and sometimes almost missionary fervor to the organizations they serve.

There are chapters on the Red Cross, National Association for the Study and Prevention of Tuberculosis, the National Foundation, American Cancer Society and the American Heart Association. Shorter discussions of the National Society for Crippled Children and Adults, National Association for Mental Health, United Cerebral Palsy Association, the National Society for the Prevention of Blindness, and mention of various other agencies.

Mr. Carter gives statistics of numbers affected, amount contributed and some idea of how money is spent. He tells something of the origin and development of several of the organizations. Gives brief biographies of such people as Clara Barton and Basil O'Connor. Reports little known facts, such as why the Red Cross charged for hospitality to our troops in rear-area clubs (to equalize the higher pay received by our troops compared to our Allies). Relates the fits and starts of treatment and prevention of polio and even a brief summary of viral research. Most of the health agencies are praised. However, several are singled out as examples of the inadequacy of funds received to cope with the enormity of the problems.

In chapters, "The Firing Line" and "The Hard Sell," Mr. Carter discusses such topics as campaigns for funds, duties of a state representative and pros and cons of "united" versus "independent" appeals for funds. A history of the development of United Funds is given. Apparently Denver in 1887 was one of the early attempts at the "united method" of giving to local welfare agencies.

This is a good book for information about national voluntary health organizations and can be used as a start for more intensive exploration by the use of the section on "Other Reading."

Richard B. Garnand, M.D.

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